

NORTH SHORE UNIVERSITY HOSPITAL
RULES AND REGULATIONS
OF
THE MEDICAL STAFF

Signed _____


Chair of the Medical Board

As Amended through November 23, 2021.

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**RULES AND REGULATIONS
OF
THE MEDICAL STAFF**

DEFINITIONS

These Rules and Regulations shall apply at both the Manhasset and Syosset Campuses of the Hospital. Unless otherwise defined in these Rules and Regulations, all capitalized terms shall have the same meaning as in the Bylaws of the Medical Staff.

A. GENERAL POLICIES – General statement regarding DOH and The Joint Commission

The actions of the Medical Staff, Allied Health Professional Staff and Graduate Medical Staff shall be governed by the Medical Staff Bylaws, these Rules and Regulations, hereinafter set forth, the Resident/Fellow Manual, as well as the New York State Hospital Code, all federal, state and local statutory and administrative law pertaining to hospitals and the practice of medicine, dentistry, podiatry and allied health professions, as well as hospital and departmental policies and procedures.

1. If a staff member has been found to have violated these Medical Staff Rules and Regulations that staff member shall be subject to discipline in accordance with the procedures of Articles VIII and IX of the Bylaws of the Medical Staff and these Rules and Regulations.
2. It is required that every practitioner comply with and participate in, the Quality Management/Performance Improvement program which has been established to maintain quality patient care and ensure optimum utilization of hospital beds and medical services.
3. In order to promote the advancement of medical education and thereby improve quality of care, Medical Staff members are expected to participate in the Hospital's teaching programs if requested by their Department Chair.¹

B. QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

In addition to satisfying the requirements set forth in Section 3.2 of the Medical Staff Bylaws, applicants to the Medical Staff also shall:

1. Be board certified or board eligible by a board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), subject to the following:

¹ References in these Rules and Regulations to the "Department Chair" shall mean the "Department Director" on the Syosset Campus.

- a) For physicians who are foreign trained and not eligible to take specialty boards, equivalent certification as determined by the Department Chair is an acceptable alternative;
 - b) For physicians who are board eligible at the time of initial appointment, board certification is required within 5 years. If board certification is not achieved within the five year period, then, at the time of the next reappointment, the Department Chair shall review the application and recommend to the Credentials Committee whether to approve continuing Medical Staff membership; and
 - c) The Department Chair may request that the Credentials Committee approve an exception to the requirement of board certification or board eligibility.
2. Applicants to the Medical Staff shall have the burden to document their background, experience, training and demonstrated competence, participation in relevant programs of continuing education, adherence to the ethics of their profession, their good reputations, and their ability to work with and be supervised by others, with sufficient adequacy to assure the Medical Board and the Board of Trustees that all patients treated by them in the Hospital will be given consistently high quality professional care fully consistent with prevailing standards of medical practice and conduct in their specialty, sub-specialty or area of practice; that they will cooperate fully and with sustained interest in the overall functions, activities and responsibilities of the Hospital; and that they will afford all patients all rights guaranteed by applicable statute or regulation and the Medical Staff Bylaws and these Rules and Regulations. These qualifications, criteria, and performance standards are designed to assure the Board of Trustees and the Medical Staff that Hospital patients will receive one level of quality patient care.
 3. The process of appointment will be the same for applicants holding or proposed for administrative positions.
 4. No practitioners shall be entitled to membership on the Medical Staff or to clinical privileges at the Hospital merely by virtue of the fact that they are licensed to practice their profession, or that they are members of or certified by any professional organization, or that they have or have had professional privileges at other hospitals.

C. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

1. APPLICATION FOR APPOINTMENT AND REAPPOINTMENT

Applications for membership on the Medical Staff shall include not less than the following:

- 1.1 Full information concerning the applicant's education, training, license and practice; previous, concurrent, and pending hospital appointments and medical staff member-

ships; past, present, and pending academic affiliations and titles; membership in professional societies;

- 1.2 The applicant's attestation that he/she is physically, mentally and emotionally competent to exercise the Clinical Privileges requested, evidence of the applicant's current health status, and any additional health-related information as may be required by the New York State Department of Health and as may be requested by the Medical Board and/or the Hospital. A recorded medical history and physical examination shall be required of all applicants for initial appointment, and may be required of applicants for reappointment;
- 1.3 Current competence in performing the requested privilege(s) by peer(s), in the same professional discipline as the applicant, with personal knowledge about the applicant's professional performance in areas including: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. This process includes an assessment for proficiency in the six areas of general competencies adapted from the Accreditation Council for Graduate Medical Education. Sources for peer recommendations may include the following: i) an organization performance improvement committee, the majority of whose members are the applicant's peers, ii) reference letter(s), written documentation, or documented telephone conversations(s) about the applicant from a peer(s) who is knowledgeable about the applicant's professional performance and competence, iii) a Department or major clinical service chairperson who is a peer, or iv) the Medical Board. Additional details with respect to Northwell Health's peer reference requirements are set forth in Northwell's policy and credentialing applications;
- 1.4 The statement and acknowledgment that, by applying for appointment to the Medical Staff, the applicant: (1) waives confidentiality as to all information requested in the application; (2) authorizes the Hospital and the Medical Board to consult with persons, whether or not listed as references, who, in the opinion of the Hospital, may have relevant information concerning the applicant, including, but not limited to, his or her license, specific training, experience, current competence and health status as such relates to the ability to perform the Clinical Privileges requested; (3) authorizes all persons consulted to provide such information; (4) acknowledges that the Hospital and Medical Board may inspect all records and documents that the Hospital and/or Medical Board deem to be material to the application; (5) acknowledges that the Hospital and any other Northwell Hospital where the applicant exercises or applies for Clinical Privileges may share among themselves relevant quality assurance, peer review and related information reflecting his or her professional competence and character; (6) agrees to provide a reassessment of his or her health status as frequently as necessary, but no less than annually; (7) agrees to take no action against the Hospital, its Board of Trustees or any Trustee thereof, members of the Medical Staff or Hospital employees or agents, and any institution or person supplying information or evidence thereto, for acts performed or statements made, in good faith and without

malice, in connection with evaluating the applicant or the applicant's credentials, performance or character; and (8) agrees not to sue and to release all of the foregoing to the fullest extent permitted by law in connection with all activities pertaining to the Hospital's performance of its credentialing, privileging and appointment responsibilities;

- 1.5 The applicant's acknowledgment that he or she shall maintain professional liability insurance covering the applicant's practice and clinical duties at the Hospital, and that he or she will use such insurance coverage in the event of a litigation that also names the Hospital and/or its employees as a defendant. Such insurance shall name the Hospital and Northwell Health as certificate holders, with minimum limits not less than those set by the Board of Trustees from time to time, with the name of the insurance carrier and the policy number. Where the applicant practices or seeks to practice at more than one Northwell Hospital, the insurance shall also name either such other Northwell Hospitals or Northwell Health as additional certificate holders. This information shall be provided by the applicant in the form of an insurance certificate. The applicant also shall verify that (i) he or she shall notify the Hospital in writing ten (10) days in advance of any change in his or her insurance coverage or classification of insurance coverage (or, if the practitioner receives less than ten (10) days' notice, at least one business day in advance of any change), and (ii) upon appointment to the Medical Staff, he or she shall provide a certificate from his or her insurance carrier(s) stating that the practitioner shall be given such notice as is provided by the standard form of insurance contract and shall request that the insurance carrier provide such notice to the Hospital and the Medical Staff Services Central Office;
- 1.6 The requirement that the applicant identify the nature and extent of Clinical Privileges for which application is being made in accordance with the approved method of delineation adopted by the Clinical Department concerned;
- 1.7 A statement that the applicant will appear for interviews in connection with his/her application if requested by the Department Chair or his/her Designee, the Credentials Committee, the Medical Board and/or the Board of Trustees;
- 1.8 A statement identifying the status of and basis for: (1) any pending legal action commenced or claim made against the applicant in connection with his or her professional activities in this or any other state or any other country, and any final judgments or settlements in any professional liability action in which he or she is or was a party; (2) any challenge to, investigation of, or official action regarding a voluntary or involuntary relinquishing of the applicant's license or registration or status as a Medicaid or Medicare provider; (3) any pending complaint, report, charge or proceeding, or any finding or action taken as a result of a complaint or report about the applicant made to or by any federal, state or local government or professional licensing or disciplinary agency, foreign or domestic, including, but not limited to, the New York State Office of Professional Medical Conduct, Office of Professional

Discipline, Office of Health Systems Management, Department of Health, Bureau of Controlled Substances, Department of Education, Department of Mental Hygiene, and any predecessor or successor of any of these agencies, and any investigation relating thereto; (4) any previous or pending voluntary or involuntary termination, limitation, suspension, resignation or other discontinuation of the applicant's Medical Staff membership, Clinical Privileges or employment of any kind at any hospital or healthcare facility or denial of any application therefor; (5) any guilty plea or conviction with respect to a crime in any jurisdiction; (6) any and all information relating to findings pertinent to violations of patients' rights as set forth in any applicable statute or regulation; (7) any denial or revocation of membership in a professional society; and (8) any denial or revocation of participation in a third-party payor contract;

- 1.9 The applicant's Drug Enforcement Administration (DEA) number, if applicable, and information as to whether the applicant's narcotic license has ever been or is in the process of being investigated, suspended or revoked;
- 1.10 The applicant's signed acknowledgment of his or her obligation to (1) comply with applicable federal, state and local statutes, rules and regulations, (2) obtain, read and abide by the Medical Staff Bylaws and these Rules and Regulations, and comply with all applicable Northwell, Hospital and Department policies including, but not limited to, those set forth in the Hospital Administrative Policies and Procedures Manual, the Patients' Bill of Rights, the Hospital's Notice of Privacy Practices and the Hospital's policies on the privacy and security of patient information as set forth in any amendments thereto, (3) cooperate with and participate in the Hospital's quality assurance and performance improvement program, risk management, legal compliance and malpractice prevention programs, and (4) abide by generally accepted principles of professional ethics;
- 1.11 A sworn statement by the applicant that all information provided by him or her is complete, true and accurate;
- 1.12 The applicant's agreement to timely provide to the Department Chair or his/her Designee, the Credentials Committee, the Medical Board and/or the Board of Trustees, any and all additional information as such person or body may request; and
- 1.13 The applicant's agreement and acknowledgement of his or her responsibility (a) to notify the Hospital, Department and Medical Staff Services Central Office in writing within five (5) days of any change in the information submitted in connection with the application, or any additional facts and information that arise or become known to the applicant after submission of the application that are germane to the information previously provided in the application, and (b) to notify both the Medical Staff Services Central Office and the applicant's Department Chair in writing within five (5) days of any such change or additional facts and information that arise or become known following approval of the application and during any term of appointment; and

1.14 Where the applicant practices or seeks to practice at more than one Northwell Hospital, the applicant's designation of the principal Northwell Hospital (and, if applicable, the Campus thereof) at which he/she intends to practice.

2. REVIEW OF APPLICATION AND RECOMMENDATION

2.1 Upon receipt of a completed application, the Medical Staff Services Central Office shall request information from hospitals and other health care facilities with which the applicant states he or she has ever been associated to confirm the accuracy and completeness of information provided in the application. Peer references, documented in the manner required by the Hospital, shall be requested from the individuals identified by the candidate as described above in paragraph 1.3 of this Section C of these Rules and Regulations.

2.2 The National Practitioner Data Bank shall be queried and primary source verification sought of the applicant's medical education, including residency and fellowship training, license, malpractice history and specialty board certification, as applicable. Additionally, the Federation of State Medical Boards, the Office of the Inspector General, the Office of the Medicaid Inspector General, and other sources shall be queried, as applicable. A criminal background check shall be performed.

2.3 An application shall be deemed verified when all required data and supporting documentation from sources external to the candidate have been assembled and determined to be current, true and accurate. It shall be the candidate's burden to provide a complete application that can be verified. After receiving reasonable notice, by overnight delivery service, of the requirement to do so, failure by an applicant to submit required information or documentation in a timely fashion shall be deemed to constitute his or her withdrawal of the application and also, if in connection with an application for reappointment, shall be deemed to constitute resignation from the Medical Staff effective at the expiration of his or her then current appointment. In such circumstances, the hearing and appeal procedures set forth in Article V of the Medical Staff Bylaws and in these Rules and Regulations shall not apply.

2.4 The Medical Staff Services Central Office shall forward the completed and verified application to the Chair of the Clinical Department in which Clinical Privileges have been requested or his or her Designee for further review. The Department Chair, or his or her Designee shall review the completed and verified application and other information received from the Medical Staff Services Central Office, may interview the applicant, and may conduct such other investigations or inquiries as deemed appropriate in the particular case. In performing an evaluation of an application, the Department Chair, or his/her Designee, also shall consider whether the Hospital is able to provide adequate facilities and support services to the applicant. On the basis of this review, the Department Chair, or his/her Designee shall render a recommendation to grant or deny Medical Staff membership and the exercise of the Clinical Privileges applied for. The Department Chair or his/her Designee may reject any

applicant not meeting the requirements and/or standards of the Chair's Clinical Department.

- 2.5 The recommendation of the Department Chair, or his/her Designee along, with the completed and verified application and all other collected materials shall be forwarded to the Credentials Committee of the Medical Board.
- 2.6 Absent unanticipated delays that are unavoidable, each completed and verified application for appointment to the Medical Staff should be processed and forwarded to the Credentials Committee within a one hundred and twenty (120) day period from the date that the completed application was received by the Medical Staff Services Central Office.
- 2.7 Upon receipt of the completed and verified application and the recommendation of the Department Chair or his/her Designee as to Medical Staff appointment and Clinical Privileges, the Credentials Committee shall (i) review and evaluate the qualifications of the applicant, (ii) ensure that all essential information has been obtained and validated, and that the recommendations regarding appointment are soundly based, and (iii) submit a written recommendation to the Medical Board. Prior to submitting its recommendation to the Medical Board, the Credentials Committee may, in its discretion, request the applicant to appear for an interview.
- 2.8 At its next regularly scheduled meeting after receipt of the reports and recommendations described above, or as soon thereafter as is practicable, the Medical Board shall consider the prior recommendations and any other relevant information. After consideration of all the prior recommendations and such supporting information and evidence as the Medical Board in its judgment shall deem sufficient, the Medical Board, by majority vote of those present, shall make a written recommendation as to Medical Staff membership and Clinical Privileges. Prior to making its recommendation, the Medical Board may, in its discretion, request the applicant to appear for an interview. Subject to the provisions of Subsection 2.9 below, the Medical Board's recommendation shall be transmitted to the Board of Trustees for final action in accordance with the Hospital's Corporate Bylaws.
- 2.9 If the Medical Board's recommendation is adverse to the applicant as to Medical Staff membership or the extent of Clinical Privileges, then, prior to making its recommendation final, the applicant shall be notified in writing, by overnight delivery service or personal delivery, of the recommendation and of the reasons therefor. Such notice of an adverse recommendation shall also include notice that the applicant is entitled to hearing and appeal rights with respect thereto in accordance with Article V of the Medical Staff Bylaws and these Rules and Regulations. An adverse recommendation of the Medical Board shall be final and shall be transmitted to the Board of Trustees only if the applicant does not request a hearing within the time period specified for doing so or otherwise waives his or her right to a hearing.

2.10 When the final recommendation of the Medical Board is adverse to the applicant as to either Medical Staff membership or the extent of Clinical Privileges recommended, the recommendation as transmitted to the Board of Trustees shall reflect the reasons for the adverse action. These reasons must relate to patient welfare, standards of patient care, the objectives of the Hospital or the character or competence of the applicant.

3. PROCEDURE FOR REAPPOINTMENT

3.1 Each applicant for reappointment will follow the same procedures for initial appointment set forth above in paragraphs 1 and 2 of this Section C of these Rules and Regulations, except to the extent such procedures are supplemented or expressly modified hereafter.

3.2 It shall be the duty of each member of the Medical Staff to submit his or her reappointment application form on a timely basis containing such information as may be required evidencing such member's fitness for reappointment to the Medical Staff and retention of Clinical Privileges, and his or her compliance with the Medical Staff Bylaws, these Rules and Regulations, and Hospital, Department, and Northwell Health policies and procedures.

3.3 Upon its receipt of the Medical Staff member's completed reappointment application, the Medical Staff Services Central Office shall follow the investigation and verification procedure for initial appointment set forth above in paragraphs 1 and 2 of this Section C, except that (i) the Medical Staff Services Office shall request one (1) peer reference from each Medical Staff member and shall require such reference from Medical Staff member's for whom there is insufficient practitioner-specific data, and (ii) it shall not be necessary to again verify the applicant's education and training.

3.4 The Department Chair, or his/her Designee, may recommend the maintenance, the revision, or the revocation of some or all of the applicant's existing privileges. Such recommendations shall be based on at least the following factors:

- consideration of the information form submitted by each practitioner, including evidence of current license, evidence of current board certification, DEA registration and health status;
- review of the Medical Staff member's record, including ongoing professional practice evaluation information and findings of any quality assurance and performance improvement program committees and medical malpractice history;
- review of morbidity and mortality data;
- review of medical malpractice history;
- past professional performance and practice;
- demonstrated current clinical competence;

- character, clinical judgment, and mental and physical capacity to perform the Clinical Privileges requested;
- attendance at Department meetings, participation in Department and Medical Staff committee review and evaluation functions, and continuing education;
- utilization of the Hospital's facilities for his or her patients;
- willingness and availability to consult;
- participation in the education and supervision of the Postgraduate Trainee Staff as requested by the Department; and
- relations with other members of the Medical Staff and personnel, and general attitude towards patients, the Hospital, Hospital Administration and the public.

Additional data may be sought from other Northwell Hospitals and facilities, and/or from non-Northwell sites, in the discretion of the Department Chair, or his/her Designee. When, in the judgment of the Chair or his/her Designee, data from Northwell and non-Northwell sites is insufficient to adequately assess an applicant's skills and abilities, then the Chair or his/her Designee may, in his/her discretion, utilize peer recommendations. If the Chair intends to make an adverse recommendation to the Credentials Committee, the applicant for reappointment shall be given notice of such intention as soon as possible, but in any event sufficiently before the next scheduled Credentials Committee meeting, so that the applicant may then request and participate in an informal meeting with the Medical Director, or his/her designee, to discuss and address the concerns underlying the Chair's intended adverse recommendation. The applicant shall not have a right to such informal meeting if at such time there is a formal hearing process pending. The informal meeting shall take place prior to the regularly scheduled Credentials Committee and, at the Medical Director's sole discretion, may be in person or telephonically. Neither the applicant nor the Hospital shall be entitled to an attorney at such meeting. Each Department Chair, or his/her Designee, shall make written recommendations to the Credentials Committee concerning the reappointment and Clinical Privileges of each Medical Staff member of his or her Department.

- 3.5 With respect to the reappointment of a Department Chair, the Chair of the Medical Board will review the reappointment application with input from a senior Attending member of the Clinical Department involved.
- 3.6 Physicians who were board certified at the time of their most recent appointment or reappointment are required to maintain such certification by a board recognized by the ABMS or AOA in at least one primary specialty or subspecialty. Physicians who were board eligible at the time of initial appointment are required to obtain board certification by a board recognized by the ABMS or AOA within five (5) years thereafter. Failure to maintain or obtain board certification as aforesaid shall result in rejection of their application for reappointment unless the Credentials Committee approves a request for an exception by the Department Chair or his/her Designee. Physicians who were not board certified at the time of their most recent appointment or reappointment, and who are board eligible, are required to obtain board

certification; *provided*, however, that Board certification or Board eligibility shall not be required for practitioners who apply to, or who are members of, only the Adjunct Staff, or for practitioners to hold privileges limited to visiting and reviewing patient charts at the Hospital.

D. LEAVES OF ABSENCE

1. Requests for leaves of absence shall be made in writing to the Chair of the Clinical Department in which a practitioner has privileges and shall state the reason for the request and the dates and duration of the requested leave. All leaves of absence for a single period of twelve (12) months or less may be granted by the Department Chair at his or her own discretion, with written notice to the practitioner, the Medical Board, and the Executive Director of the Hospital. If a leave of absence is to extend longer than twelve (12) months, the Chair shall transmit the request, together with his or her recommendation, to the Medical Board. The Medical Board shall make a report and recommendation concerning the requested leave, which, together with the request, shall be forwarded to the Executive Director of the Hospital for action by the Board of Trustees. The Executive Director shall inform the practitioner in writing of the final action on the request for leave of absence by the Board of Trustees.
2. Subject to paragraphs (3) and (4) below, any practitioner on leave of absence who desires to resume his/her Medical Staff appointment and clinical privileges shall submit at least fifteen (15) days' prior written notice to the Chair of his/her Clinical Department. The notice shall explain, to the Chair's satisfaction, the nature of the practitioner's activities while on the leave of absence. The Chair shall forward such notice to the Medical Board and the Executive Director.
3. In addition to the requirements of paragraph (2) above and paragraph (4) below, any practitioner wishing to return from a leave of absence granted for medical reasons must submit to the Chair of his/her Clinical Department a least fifteen (15) days prior to the anticipated date of return a letter [or medical clearance form] signed by his or her treating physician indicating that the practitioner is physically and mentally capable of resuming the activities and obligations of his/her appointment and clinical privileges. In the discretion of the Department Chair, the practitioner also may be required to obtain clearance from the Hospital's Employee Health Service prior to resuming his or her activities.
4. If the practitioner's term of appointment to the Medical Staff is scheduled to expire during the period of the practitioner's leave of absence, the practitioner must timely submit a completed application for reappointment in accordance with Section C, above, of these Rules and Regulations. If the practitioner fails to timely submit a reappointment application and his/her current appointment lapses while the practitioner is on a leave of absence, the practitioner's medical staff membership shall terminate on the last date of the current appointment. If the practitioner wishes subsequently to resume clinical activities at the Hospital, he/she shall be required to apply anew.

5. During a leave of absence, a practitioner who has a claims-made policy shall be required to maintain professional liability insurance or tail coverage in the amounts and upon the terms required by the Hospital, and shall continue to pay Medical Staff dues.

E. ADMISSION AND DISCHARGE OF PATIENTS, INCLUDING EMERGENCY PATIENTS

1. The Hospital shall accept patients for care and treatment appropriate to an acute care hospital, irrespective of their race, color, creed, sex, national origin, sexual orientation, marital status, age, veteran's status, disability, or the source of payment for their care, except that it may, in non-emergency situations, elect to exclude the prospective patient if:
 - a) the capacity of the Hospital has been reached as determined by the Executive Director, or his designee; or
 - b) the patient requires a type of medical service not authorized by the Hospital's Operating Certificate.
2. All patients, regardless of the ability to pay, shall be treated by members of the Medical Staff and shall be assigned to the Clinical Department concerned with the treatment of the disease or condition which necessitated admission. Members of the Medical Staff may admit patients only to the clinical service to which they are appointed.
3. All patients may be included in the teaching program. A practitioner may exclude a patient from the teaching program when he or she considers such participation to be detrimental to the welfare of the patient or at the request of the patient.
4. Only licensed physicians and oromaxillofacial surgeons who are members of the Medical Staff may admit a patient to the Hospital. The admitting practitioner must provide a provisional diagnosis and adhere to the admitting policies and procedures of the Hospital. All admissions are subject to review by the respective Department Chair or Chief of Division or Service.
5. Every patient admitted to the hospital shall have a single caregiver designated to take the role of the physician of record throughout the hospitalization. This attending will be clearly identified to the patient. Staff and health care team. The responsibilities of the attending of record will include at a minimum: (1) the coordination of the care of the patient among all members of the health care team; (2) as the accountable leader of the health care team, provide the main line of communication to the patients, their families and the other members of the care team; (3) documenting in the medical record a well-defined plan of care that includes fully integrating all consultant recommendations into the unified care plan; and (4) the prompt completion and accuracy of the medical record, for any necessary special instructions. The attending of record shall maintain primary

responsibility for the care of the patient unless there is an explicit and well-documented handoff of primary responsibility to another physician. This transfer of care will be clearly documented in the medical record and personally communicated to the patient/family and other members of the health care team. An accepting order or note from the accepting physician must be present in the chart prior to transfer of responsibility. Unless a formal handoff has previously been agreed to and documented in the medical record, a patient going to the operating room is the responsibility of the surgeon or person performing the procedure and remains fully under his/her care. The formal handoff must be fully documented and personally communicated to all involved persons including the patient/family and the care team.

6. Each member of the Medical Staff with admitting privileges must sign the New York State required "Notice to Physicians" acknowledgment pursuant to Sec. 405.3 of NYCRR Title 10.
7. Practitioners admitting patients shall be responsible for providing such information as may be necessary to ensure the protection of the patient from self-harm as well as protection of other patients, hospital personnel and visitors from those who are a source of danger from any cause whatsoever.
8. Each practitioner must ensure timely, adequate, professional care for his/her patients in the Hospital by being available or having available to his/her office an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of the attending practitioner to meet these requirements may result in corrective action.
9. No person who presents for medical care to the Hospital shall be removed, transferred, or discharged for the purpose of effecting a transfer from the Hospital unless such removal or transfer is carried out after a written order made by the attending practitioner that in his or her judgment such removal or transfer will not create a medical hazard to the person, and that such removal or transfer is considered in the person's best interest, despite the potential hazard of movement. Such removal or transfer shall be made only after prior notification to an appropriate medical facility and only with the consent of the person or other individual authorized to consent on behalf of the person.
10. The decision to discharge a patient must be made by the attending practitioner. The attending of record shall take full responsibility for the preparation of a comprehensive discharge plan as well as follow-up appointments and care. If the discharging physician will not be following the patient after discharge, then there will be timely communication with the physician who will be providing on-going care as per Northwell and Hospital protocols. A staff physician or physician designee, a member of the postgraduate trainee staff, a nurse practitioner, or a physician assistant may write a discharge order after discussion with the attending practitioner. The discharge note must be written on the day of discharge and shall include the condition of the patient on discharge and instructions given to the patient. At the time of discharge the practitioner shall record the final

diagnosis, complete and sign the patient's medical record. Members of the Postgraduate Trainee Staff may complete such entries so long as the attending practitioner appropriately countersigns such entries.

11. An unemancipated minor under (18) years of age shall be discharged only in the custody of his/her parent(s) or his/her legal guardian unless the parent(s), or guardian, shall otherwise direct in writing.
12. No patient shall be detained in the Hospital against his/her will, nor shall a minor under eighteen (18) years of age be detained against the will of his/her parent or legal guardian, except as authorized by law. In no event shall a patient be detained solely for the non-payment of a hospital or physician's bill for medical services. However, it is acceptable to attempt to persuade a patient to remain in the Hospital in the patient's own interest. If there is a concern that the patient lacks capacity, or there is a concern that the patient may be a danger to himself/herself or others, the patient may be temporarily detained pending a prompt psychiatric evaluation and determination of the patient's legal rights. If an adult patient lacks capacity for any other reason, and there is no legal guardian or properly designated health care agent, Administration shall be consulted. If a patient who has capacity insists upon being discharged against the advice of a member of the Medical Staff or the Postgraduate Trainee Staff, the patient shall be requested to sign the form entitled "Release for Leaving the Hospital Against Advice". The physician involved is responsible for documenting the facts and circumstances surrounding the act of the patient leaving the Hospital against medical advice. In the event the patient refuses to sign the form, the patient's refusal must be documented in the patient's chart.

F. INFORMED CONSENT

1. GENERAL REQUIREMENTS

- a) Upon admission the patient shall be requested to sign a general admission consent form. If the patient lacks capacity to provide the general admission consent, then the patient's health care agent (if any), relative, parent (if patient is a minor) or legal guardian shall be requested to sign the general admission consent form.
- b) A properly designated health care agent may make any decision that a patient could make if the patient were capable of giving consent. Refer to Hospital Administration Policy and Procedure regarding Health Care Agents and Proxies. Any question concerning a health care proxy document shall be referred to Hospital Administration.
- c) Informed consent must be obtained prior to performing a non-emergency surgery, treatment, procedure or invasive diagnostic procedure which bears risk to the life or health of the patient. Informed consent must be obtained prior to the non-emergency administration of blood and blood products. Informed consent must be obtained either by a member of the Medical Staff credentialed to perform the treatment or procedure, or, in cases where the treatment or procedure is to be

performed by a member of the Allied Health Staff or Graduate Medical Staff who are credentialed to perform such procedure, such individual may obtain such consent.

- d) The informed consent discussion should include, but not be limited to, a description of the risks, benefits and alternatives to the proposed procedure or treatment.
- e) The Medical Staff member or other individual as noted in (c) above, will be responsible for documenting the informed consent discussion and for completing any required hospital forms in the patient's medical record.
- f) The informed consent requirement may be waived or modified under the following circumstances:
 - i. In the physician's judgment, an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.
 - ii. When the Medical Staff member has reason to believe that the patient would suffer immediate and severe harm from a discussion of the patient's condition and need for treatment.

2. PERSONS QUALIFIED TO CONSENT TO TREATMENT

- a) Persons with the capacity to make health care decisions who are eighteen (18) years of age or older may consent to their own treatment. If the responsible Medical Staff member is uncertain about a patient's ability to consent to treatment, a psychiatric evaluation should be obtained.
- b) A person with the capacity to make health care decisions who is under eighteen (18) years of age may consent to his/her own medical treatment if that person is a parent, is pregnant, has been married or is married or qualifies as an "emancipated minor". An emancipated minor is a person who has not yet reached the age of eighteen (18), but who has assumed all of the responsibilities of adulthood, e.g., is self-supporting and lives apart from parents. The "emancipated minor" must be sufficiently mature and intelligent to give informed consent and the Medical Staff member must document the minor's ability to consent to the treatment. A minor may consent to his/her own treatment which involves birth control, abortion, sexually transmitted disease or substance abuse treatment and the parents should not be notified of such treatment, unless the Medical Staff member is requested to do so by the minor.
- c) Legal consent to treatment may only be given by a patient, a parent (if the patient is a minor), a properly designated health care agent, a legal guardian or a court appointed guardian.

3. RIGHT TO REFUSE TREATMENT

- a) An adult with the capacity to make health care decisions has the right to refuse treatment. This right includes the ability to refuse or request the withdrawal of life-saving treatment. A psychiatric consultation should be obtained if there is any doubt about a patient's capacity to consent or refuse treatment.
- b) A person with the capacity to make health care decisions who is under eighteen (18) years of age may also refuse to consent to his/her own medical treatment if that person is a parent, is pregnant, has been married or is married or qualifies as an "emancipated minor," as described above. A minor may also refuse to consent to his/her own treatment which involves birth control, abortion, sexually transmitted disease or substance abuse treatment.
- c) The Medical Staff member must document a patient's refusal of treatment in the medical record.
- d) A Medical Staff member cannot deny lifesaving treatment to a minor even if a parent refuses to consent to the treatment unless there is a valid "do not resuscitate" order or a valid order to withhold treatment.

G. HISTORY AND PHYSICAL EXAMINATION

1. The complete medical history and physical examination must be completed within twenty-four (24) hours of admission. If a complete history and physical examination has been obtained within thirty (30) days prior to admission, the requirement of the preceding sentence may be satisfied if a durable, legible copy of this report is placed in the patient's hospital medical record at the time of, or prior to, any anticipated procedure provided that an update to the patient's condition or a notation of no change has been recorded at the time of the admission or procedure. The admission history and physical examination, if recorded by a member of the postgraduate trainee staff, physician assistant, or nurse practitioner shall be reviewed with and countersigned by the attending physician within twenty-four (24) hours of admission and prior to any major diagnostic or therapeutic intervention, but no later than twenty-four (24) hours of admission.
2. If the admission history and physical for an operative or invasive procedure is performed by a physician who is not a member of the Hospital's medical staff, the attending physician shall review the history and physical examination and attest to its accuracy by countersigning. Individuals who are not licensed independent practitioners may perform part or all of a patient's medical history and physical examination under the general supervision of the attending physician. The attending physician shall review and countersign the history and physical examination before the operation or procedure.

3. All delays and deferrals in the history and/or physical examination must be justified in the patient's medical record.
4. The physical examination shall include examination of the breasts and a screening cervical cytology smear on women 21 years and older unless the patient refuses or the examination is medically contraindicated. The uterine cytology smear may be deferred if one has been performed in the last three (3) years. Insofar as it is possible to identify patients who may be at risk for sickle cell anemia, all potentially susceptible patients including infants over six (6) months of age shall be examined for the presence of sickle cell hemoglobin unless testing has been previously performed. Results or refusal of these test and examinations shall be recorded in the medical record.
5. When obtaining the admission history, the admitting physician shall inquire about the patient's recent exposure to communicable diseases. Whenever there are positive findings, the physician shall take appropriate measures relative to the care of the patient and the protection of other patients and staff, which may include isolation of the patient.
6. When the history and physical examination, appropriate diagnostic tests, or informed consent are not completed before a surgical procedure, or any potentially hazardous diagnostic procedure, or if the history and physical examination is required to be countersigned and such requirement has not been met, the procedure shall be canceled, unless, in the judgment of the surgeon or attending physician, it is determined that the risk of delay is greater than the risk of proceeding in the absence of conformity to these requirements and that determination is recorded on the patient's chart and signed by the surgeon or attending physician.
7. Physicians, dentists or podiatrists admitting patients for the treatment of malignant lesions, including in situ carcinoma based upon pathology reports prepared by pathologists not on the Medical Staff of the Hospital or Long Island Jewish Medical Center must submit the pathology data (including slides of tissue sections) on which the results were based. The pathology data must be submitted to the Hospital's Department of Pathology for review by the Hospital's pathologists prior to elective surgery or other major intervention (e.g., chemotherapy, radiation therapy). Exceptions to this rule must be justified in the chart by the responsible attending physician, dentist, or podiatrist and approved by the Chair of the responsible attending's department, the Chair of the Department of Pathology, either of these Chair's designees, or the Medical Director of the Hospital.
8. The Hospital will accept laboratory results for inpatients from laboratories located in New York State which have a valid laboratory permit issued by either the New York State Department of Health or the New York City Department of Health, or from a physician's office with a CLIA-approved laboratory.
9. A licensed independent practitioner shall perform a medical history and physical examination on a non-inpatient in accordance with the applicable hospital policy and

procedure for non-inpatients in an Article 28 ambulatory site. This policy and procedure specifies the different requirements which pertain to Primary Care and Specialty Care Services.

H. MEDICAL RECORDS

1. The practitioner of record shall be responsible for making entries in the medical record that accurately reflect the patient's medical condition (whether inpatient, outpatient, emergency or home care). The contents of the record shall be pertinent and current.
2. The medical record shall contain in addition to the demographic data, an appropriate history (chief complaint, present illness, past history, family history, review of systems), and physical examination, provisional diagnosis, clinical laboratory reports, x-ray reports, consultations, medical and surgical treatment, tissue report, progress notes, final diagnosis, discharge summary and autopsy findings, if performed.
3. The practitioner of record is responsible for ensuring that the entries in the medical record reflect that he/she is directly involved in the overall care of the patient. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity and transferability of care. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes must reflect the reassessment of the patient's condition taking into account the team members' findings, present diagnostic consideration and treatment plans integrating all consultants' evaluations and recommendations. Except as provided in the Northwell Alternate Level of Care Policy, progress notes shall be written at least daily by the attending of record or the covering physician.
4. Entries in the medical record must demonstrate that the practitioner of record was directly involved in the overall care of the patient. Notwithstanding any requirements to the contrary in the electronic medical record, all hand-written clinical entries in the patient's medical record shall be legible, accurately dated, timed and signed (signatures shall consist of the full last name and first initial of the recording person). All handoffs in care must include a formalized sign-out enabling the covering physician to have the necessary information to continue the active care of the patient at all times whether within the same group or via a coverage group. With the exception of routine overnight or weekend coverage any transfer of care will be clearly identified in the medical record and communicated to the patient/family and other members of the health care team. If the entry reflects a prior encounter with the patient, the date and time of such encounter should be reflected in the medical record.
5. Symbols and abbreviations may be used only when they have been approved by the Medical Board. An official record of approved and unapproved abbreviations shall be kept on file in the Health Information Management Department, and on each nursing unit.

6. A practitioner's routine orders, when applied to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.
7. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and shall be dated and signed by the responsible practitioner at the time of discharge of all patients.
8. Entries may be made in the progress note of the medical record by medical or dental students and shall be countersigned within twenty-four (24) hours by the attending physician or dentist or by an appropriately credentialed physician.
9. Members of the Postgraduate Trainee Staff, and Allied Health Professional Staff (who are appropriately credentialed and privileged): physician assistants, nurse practitioners and nurse midwives may dictate discharge summaries, provided that the summaries are reviewed and countersigned by the appropriate attending physician of record. Nurse midwives may dictate a labor and delivery report, provided that the report is reviewed and countersigned by the appropriate attending physician of record. Nothing contained in this Section shall be interpreted to in any way change the attending physician's ultimate responsibility for the patient's care and the completion of the patient's medical record.
10. Members of the Postgraduate Trainee Staff must be supervised by the attending practitioner of record or a designee. The attending practitioner is responsible for countersigning the history and physical written by a member of the Postgraduate Trainee Staff within twenty-four (24) hours of admission. Further documentation in the medical record must evidence the level of involvement by the attending practitioner of record. Merely countersigning the notes written by a member of the Postgraduate Trainee Staff is not sufficient documentation of the attending's involvement and supervision.
11. The Medical record discharge face sheet for a patient must be reviewed for accuracy and signed by the attending physician, dentist or podiatrist of record.
12. The following types of cases do not require a dictated or written final summary to complete the medical record:

- Normal Newborns
- Normal Deliveries
- Pediatrics – less than 48 hours stay
- Cardiac Catheterization – less than 48 hours stay
- Ambulatory Surgery Cases
- Ambulatory Endoscopy Cases
- Lithotripter Cases
- In-Vitro Fertilization Cases

Chemotherapy – less than 48 hours stay
Intravenous Gammaglobulin Cases – less than 48 hours stay
Uncomplicated Surgery Cases – less than 48 hours stay

Nonetheless, the medical record for such procedures shall not be deemed complete unless it includes an appropriate entry by the responsible physician containing a discharge note with outcome of hospitalization, the disposition of the case, any provisions for follow-up care and a final diagnosis.

13. All practitioners shall comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Hospital's policies and procedures governing patient confidentiality and the release of patient information. (See Section J, below, Regulatory Requirements - HIPAA).
14. Medical records may be removed from the Hospital's jurisdiction and safe-keeping only as required or authorized by law. All records are the property of the Hospital and shall not be removed from the Hospital without permission of the Executive Director, or his or her designee. The patient has a right to a copy of the medical record after appropriate request to Health Information Management. Unauthorized removal of medical records from the Hospital by Medical Staff members shall be grounds for corrective action.
15. Nothing contained in a patient's medical record shall be removed from it. If an alteration needs to be made to an entry in a patient's medical record, the practitioner who made the entry shall strike through, but not obliterate the erroneous notation and a fully explanatory new entry, dated and signed, shall be made to correct or alter a previous entry. If a physician wishes to revise a note previously written by a member of the Postgraduate Trainee Staff or a member of the Allied Health Professional Staff who is under his or her supervision, then the physician should enter a separate note, which outlines his or her own findings.
16. Medical records must accompany the patient at all times while the patient is in the Hospital.
17. Each member of the Medical Staff, Postgraduate Trainee Staff and Allied Health Professional Staff shall be given a password or other means of user identification, which will allow the practitioner access to the Hospital's information systems. No practitioner shall give or disclose to another person, or allow another person to use the practitioner's password(s) to access protected health information unless requested by the Information Services Department, whether or not such other person is an authorized user on the Hospital's information system. The assigned personal password constitutes the practitioner's legal signature and the practitioner accepts full responsibility for all actions taken as a result of the use of the practitioner's password. In the event that any practitioner reasonably suspects or becomes aware of any unauthorized disclosure or use of the practitioner's password, the practitioner shall immediately report such unauthorized use or disclosure to the Chief Information Officer or Compliance Officer

of the Hospital who shall take appropriate action. Each member of the Medical Staff and Allied Health Professional Staff shall log-off the Hospital's information systems, or password protect the computer screen, to ensure that a computer session cannot be accessed by any other individual when the computer is left unattended or at the conclusion of the computer session.

18. No practitioner shall print, copy or download patient information from the Hospital's information systems to any hard drive, diskette, tape, or other storage device or otherwise copy any paper record for purposes other than to provide medical care to the patient or for Hospital/Northwell Institutional Review Board (IRB) approved research or educational purposes. Such practitioners shall be solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded.
19. The Medical Staff Departments where electronic and computer transactions and authentications are utilized will work in conjunction with the Information Services Department of the Northwell and the Health Information Management Department of the Hospital to develop and implement criteria and procedures that ensure appropriate and confidential use of electronic or computer transactions and authentications, including the identification of those categories of practitioners and hospital personnel who are authorized to utilize electronic or computer generated transmissions.
20. Delinquent Medical Records
 - a) Records of discharged patients shall be completed within thirty (30) days of such discharge.
 - b) A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical resume or final progress note, and the recording, without use of symbols or abbreviations, of all final diagnoses and any complications. Completeness implies the transcription of any dictated record content and its insertion into the medical record.
 - c) Suspension of privileges for incomplete medical records shall be imposed when:
 - i. a Medical Staff Member has four incomplete medical records thirty (30) days after discharge of the patient and he or she has been notified of the delinquent records.
 - ii. a Member of the Postgraduate Trainee Staff has not completed a medical record within thirty (30) days after the patient's discharge. Members of the Postgraduate Trainee Staff with incomplete medical records will be assigned to the Health Information Management Department until all of their incomplete records are completed, and shall be subject to such

other sanction(s) as may be approved by the Medical Board and set forth in Medical Staff Bylaws.

- d) Repeated Suspensions: The Director of the Health Information Management Department shall report to the relevant Clinical Department Chair a physician's pattern of repeated suspensions for delinquent medical records. Such reports shall be included in the physician's credentials profile and shall be considered as part of the recredentialing process, at the time that the physician applies for reappointment to the Medical Staff.
- e) Any suspension or other corrective action taken pursuant to this Section shall not give rise to the due process right granted to Medical Staff members under Article VIII and IX of the Bylaws of the Medical Staff.

I. GENERAL CONDUCT OF CARE

1. ORDERS

- a) All orders for treatment shall be (i) in writing and signed on the Order Sheet or (ii) entered into the electronic medical record, by an appropriately credentialed practitioner. Medication orders shall include the name of the drug, the strength expressed in the metric system, the dosage frequency, the route of administration and the duration of therapy or number of doses to be administered. Written orders may be issued by a Medical Staff member, a postgraduate trainee staff member, a physician assistant, nurse practitioner, certified registered nurse anesthetist and nurse midwife.
- b) A physician assistant may write medical orders, including those for controlled substances, for inpatients under the care of the physician responsible for his or her supervision. Countersignature of such orders may be required if deemed necessary and appropriate by the supervising physician or the Hospital, but in no event shall countersignature be required prior to execution.
- c) Other than in an emergency, telephone/verbal orders shall be used sparingly. Practitioners who are authorized to issue verbal or telephone orders shall include medical staff members, postgraduate trainee staff members, certified registered nurse anesthetists, physician assistants, nurse practitioners, and nurse midwives. A registered professional nurse, pharmacist, respiratory therapist, physical therapist, occupational therapist or a member of the Allied Health Profession's Adjunct Staff can carry out and record a verbal order or telephone order when the order is within the scope of their practice or clinical privileges. Staff members receiving a verbal order should repeat back the order to assure its accuracy. The practitioner giving a telephone order must request that the order be read back by the person taking the order after the order has been transcribed to assure its accuracy.

- d) Telephone/verbal orders for treatment must be authenticated by the prescribing practitioner as soon as possible, but no later than 48-hours after the order is given. A covering physician may authenticate an order given by the prescribing practitioner.
- e) It is desirable that the generic name of a medication as stated in the Hospital's Formulary be used. When a practitioner prescribes a medication by trade name, he does so with the clear understanding and agreement that the Hospital Pharmacist may dispense a generically equivalent drug.
- f) The Pharmacy is authorized to therapeutically interchange a product when such request for an interchange is received and approved by the Medical Board.
- g) The Department of Anesthesiology is responsible for preanesthesia medication orders directly related to the anesthesia care of patients receiving general anesthesia, major regional anesthesia and monitored anesthesia care. The Department of Anesthesiology is not responsible for preoperative medication orders which are unrelated to the anesthetic management of the patient.
- h) Requisitions for blood and blood products for transfusion shall include the indications for transfusion.
- i) All drugs used for investigational purposes shall have the prior approval of the Department Chair (or Chief of a Division) and of the IRB.
- j) Medication orders are subject to the Hospital's "Automatic Stop Order Policy."

2. SURGICAL SERVICES

- a) The Surgeon shall ascertain that a record of the following appears in the patient's medical record.
 - i. A medical history and physical examination including the indication for the procedure recorded in accordance with the requirements of the Medical Staff Bylaws and Section G of these Rules and Regulations.
 - ii. A preoperative diagnosis and appropriate diagnostic tests.
 - iii. A written, signed informed consent consistent with the requirements of these Rules and Regulations. Written consent shall be obtained prior to the operative procedure except in those situations where the patient's life is in jeopardy and suitable signature cannot be obtained. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from a parent or guardian or next of kin,

the circumstances shall be fully explained in the patient's medical record.

- b) A preanesthesia assessment shall be made to include medical history, co-morbid conditions, prior anesthetics, allergies, medications, pertinent laboratory tests, physical findings and baseline vital signs. The admitting history and physical will provide information for this assessment.

A determination shall be made whether or not the patient is a suitable candidate for the proposed procedure and anesthesia. It is understood that all laboratory data may not be available at the time of initial assessment and that the patient will be reassessed on the day of the procedure by the care team for completeness of preparation and any change in patient status.

- c) The surgeon shall, prior to commencing surgery, verify the patient's identity, procedure and the site and side of the body to be operated on by completing the Patient Identification Procedure and Surgical Site Verification check list.
- d) All preoperative orders are automatically canceled upon operation and new post-operative orders must be written immediately.
- e) The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation, intra-operative management, and post anesthetic follow-up of the patient's condition.
- f) All operative or other high-risk procedure reports shall be dictated or written in the medical record by the operating surgeon immediately (upon completion of the operation or procedure, before the patient is transferred to the next level of care) following surgery. Operative or other high-risk procedure reports shall contain the name of the primary surgeon and assistants, indications for surgery, technical procedure(s) performed and description of the procedure(s), findings, estimated blood loss, complications, specimens removed or altered, general condition of the patient and postoperative diagnosis. The exception to this requirement is when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full operative or other high-risk procedure report can be written or dictated within twenty four hours of the operative or other high-risk procedure.
- g) All anatomical parts, tissues and devices removed during a procedure shall be delivered to the Hospital Pathologist who shall make such examination as he or she may consider necessary to arrive at a diagnosis. The operating surgeon shall be responsible for completing the required forms that identify removed tissue and which must accompany tissue to the Pathology Department. A report of the Pathologist's findings shall be filed in the patient's medical record and copy of the report shall be available to the Surgical Case Review/Tissue Committee.

- h) When surgery or high risk procedures are performed by members of the Postgraduate Trainee Staff, documentation by the attending surgeon in the medical record must reflect that the attending surgeon was physically present during the key portion of the surgery or high risk procedure. Documentation must also reflect that the attending surgeon was immediately available to furnish services during the entire surgery or procedure.
- i) The anesthesiologist shall have overall responsibility for patient supervision in the Post Anesthesia Care Unit, subject to the post-operative orders of the patient's surgeon, who is responsible for being on call for any emergency complications. The anesthesiologist is responsible for determining when a patient is sufficiently recovered to permit the patient's transfer to the next level of care, e.g., ICU, step down unit, or floor bed.

3. DENTAL PATIENTS

- a) All general dentistry patients shall be admitted by and under the supervision of a physician who is a member of the Medical Staff. The discharge of the patient shall be on the written concurrence of both the dentist and physician involved.
- b) The dentist's responsibilities shall include, but shall not be limited to:
 - i. A detailed dental history.
 - ii. A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
 - iii. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding normally developing teeth, shall be sent to the hospital pathologist for examination. Extracted tooth/teeth must be disposed of according to the Infection Control Guidelines.
 - iv. Progress notes as are pertinent.
 - v. Clinical resume or summary statement.
- c) The responsibilities of the attending physician shall include, but not be limited to:
 - i. Medical history pertinent to the patient's general health.
 - ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.

iii. Supervision of the patient's general health status while hospitalized.

- d) An oral surgeon may admit and discharge patients directly from the oral surgery service. Oral surgery patients are to be cared for according to all the rules and regulations promulgated for surgical services.

4. PODIATRIC PATIENTS

- a) All podiatric patients shall be admitted by and under the supervision of a physician member of the Medical Staff, but the discharge of the patient shall be on the written concurrence of both the podiatrist and the physician involved.
- b) The responsibilities of the podiatrist shall include, but shall not be limited to:
- i. A detailed podiatric history and physical examination to justify hospital admission; and
 - ii. Completion of all appropriate elements of the patient's medical record, including any orders for medication and treatment consistent with regulatory requirement and the policies of the Medical Staff, and the recording of such progress notes as are pertinent to the podiatric condition.
- c) The responsibilities of the physician shall include, but shall not be limited to:
- i. Medical history pertinent to the patient's general health.
 - ii. A physical examination to determine the patient's condition prior to the podiatric procedure or treatment.
 - iii. Supervision of the patient's general health status while hospitalized.

5. CONSULTATIONS

- a) Except as otherwise provided for by the Medical Board, any qualified practitioner with appropriate clinical privileges in the Hospital may be called for consultation within his or her area of expertise.
- b) The patient's attending practitioner of record is primarily responsible for requesting the consultation when indicated and for calling in a qualified consultant. The request for consultation and the consultation report shall then be incorporated into the patient's medical record.

c) Consultation is indicated in the following situations:

- i. In cases where the scope of care needed by the patient is beyond the delineated clinical privileges of the practitioner.
- ii. In unusually complicated situations where specific skills of other practitioners may be needed.
- iii. In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms; e.g., drug or alcohol withdrawal.
- iv. For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health.
- v. When requested by the patient or the patient's family; or
- vi. Those situations specifically designated elsewhere in these Rules and Regulations, or in the Policies and Procedures of the various Clinical Departments or Special Care Units.

d) Physicians serving as consultants are, at a minimum, responsible to do the following:

- i. Personally evaluate the patient in a timely manner, but no longer than 24 hours following a consultation request unless otherwise requested in the consultation.
- ii. Document immediately in the chart pertinent facts and recommendations, even if a more comprehensive dictation will follow and communicate the results of the consultation to the physician of record or his/her designee.
- iii. Personally communicate as soon as practicable with the physician of record to review the results of the consultation and any follow-up that is suggested.

e) The consultation will include:

- i. the answer to the question asked;
- ii. a clear plan for follow-up visits by the consultant as mutually agreed to by the physician of record and the consulting physician;

- iii. adequate contact information so that the consultant can be reached easily if needed between visits; and
 - iv. in cases where the physician of record and the consulting physician agree, documentation of transfer of care to that consultant.
- f) Consultations by physicians or dentists not on the Medical Staff must have (i) the prior permission of the pertinent Department Chair (or designee thereof), (ii) provided the required documentation to the Medical Board and (iii) have been granted temporary privileges as provided for in the Medical Staff By-laws. Such permission must be recorded in the patient's medical record. Whenever possible, the attending physician or dentist of record or a designee shall be physically present during such consultation.
- g) A pre-procedure medical consultation is not mandatory for any patient and a request for such is within the discretion of the attending surgeon. In the event pre-procedure consultation for surgery patients is requested, it must be provided by a physician on the Hospital's Medical Staff except in the following circumstances:
- i. For patients undergoing surgery where continuing medical consultation is not anticipated, this consultation may be performed by a physician who is not a member of the Medical Staff. In such situations, the attending surgeon must co-sign for the pre-procedure consultation.

6. CLINICAL AND BASIC SCIENCE RESEARCH

Research is defined as activities designed to add to general knowledge.

The Institutional Review Board (IRB) is the Medical Board Committee charged with the responsibility for reviewing and approving all research activities involving human subjects and reporting those approvals to the Medical Board. The IRB review includes investigator-initiated research, projects that are interdepartmental in nature and cooperative research projects with other institutions or organizations. In addition, the IRB serves as the Privacy Board for research activities with regard to HIPAA and will determine the need for obtaining authorization from subjects and/or issuing a waiver of authorization for research projects involving human subjects. These requirements are in place regardless of the source of funding for the project.

- a) Publications, statements for publications, presentations, and or scientific exhibits which indicate or imply affiliation with the Hospital may not be published, made, or exhibited without approval in advance by the respective Department Chair or his/her designee(s). In the event that there are multiple authors, the approval of the Chair of each author or the Chair's designee shall be obtained.

Publications, statements for publication, presentations, and/or scientific exhibits published, made, or exhibited by members of the staff of the Hospital, and based upon work done at the Hospital, must indicate the relationship of the author to the Hospital, and, where appropriate, to an affiliated Medical School or University. All publications, statements for publication, presentations, and/or scientific exhibits which derive from projects supported entirely or in part by intramural Hospital research funds shall identify publicly the source of this support.

The use of any investigational drug, device or biological for patient use shall have the prior approval of the Department Chair (or Chief of a Division) and of the IRB.

7. TREATMENT OF RELATIVES

“Relatives” refers to an individual’s spouse (husband or wife) or domestic partner; biological, step, or adoptive parents, grandparents, or great-grandparents; brothers and sisters (whether whole, half, adoptive, or step-siblings); biological or adopted children, grandchildren, or great-grandchildren; spouses or domestic partners of brothers and sisters (whether whole, half, adoptive, or step-siblings); spouses or domestic partners of biological or adopted children, grandchildren, and great-grandchildren; biological, step, or adoptive parents of the individual’s spouse (husband or wife) or domestic partner; or any other person if that person resides in the same household as the practitioner.

Physicians shall not provide medical care to Relatives except in limited, extraordinary situations such as emergencies or special expertise of the physician. When treating in an emergency, the physician should only provide care until another qualified physician becomes available. In other situations, the matter shall be referred for approval from the appropriate Departmental Chair and Medical Director. If the Department Chair is making the request, approval shall be sought from the Medical Director and the Executive Director.

J. REGULATORY REQUIREMENTS

Medical Examiner. The physician of record is responsible for reporting to the Medical Examiner’s Office all deaths that might fall under the purview of the County Medical Examiner. The Medical Examiner shall be contacted if there is any question as to whether a case is reportable. It is the responsibility of the attending (physician, dentist or podiatrist) to notify the family that the patient’s death was reported to the Medical Examiner. Permission for autopsy should not be sought until it is determined that the death is not reportable to the Medical Examiner.

Infection Control. The Division of Infectious Diseases/Epidemiology/Infection Control is responsible for meeting the infection control requirements of regulatory agencies for the Hospital. Members of the Medical Staff, the Postgraduate Trainee Staff, the Allied Health Professional Staff, and the Division of Infectious Diseases/

Epidemiology/Infection Control serve as a resource to the Medical Staff to facilitate infection prevention efforts. The Medical Staff, the Postgraduate Trainee Staff and the Allied Health Professional Staff shall comply with all infection control and prevention regulations to identify infections and implement measures to prevent the transmission and development of infection. Members of the Medical Staff are mandated, as per the New York State Department of Health and local Health Departments to report infectious diseases which pose a risk to the health of the public. In addition, all Class I and Class II surgical site infections identified by a practitioner following discharge shall be recorded and reported to the Department of Epidemiology/Infection Control officer for further investigation.

Department of Health Incident Reporting. The members of the Medical Staff, the Postgraduate Trainee Staff and the Allied Health Professional Staff will assist the Department of Quality Management to ensure compliance with all New York State (NYS) Department of Health Code requirements that incidents fulfilling the NY Patient Occurrence Reporting Tracking System (NYPORTS) criteria be reported to the NYS Department of Health.

Child Abuse and Neglect. Members of the Medical Staff, Postgraduate Trainee Staff and the Allied Health Professional Staff shall be responsible for reporting suspected abuse and /or neglect of children as soon as possible to the Child Protective Services, Central Registry for Mandated Reporters. The Hospital Department of Social Work should be contacted to facilitate this reporting.

Safe Medical Device Reporting. The members of the Medical Staff, the Postgraduate Trainee Staff and the Allied Health Professional Staff will comply with the Medical Device Reporting Program, which was established by the Hospital to identify medical device related incidents in order to initiate corrective action and comply with the reporting requirements of the Safe Medical Devices Act of 1990. The members of the Medical Staff, the Postgraduate Trainee Staff and the Allied Health Professional Staff shall report any such potentially reportable incident to the Department of Quality Management.

EMTALA. The Emergency Treatment and Active Labor Act (EMTALA) (along with corresponding regulations) is a Federal statute, which applies to all Medicare participating hospitals. The Hospital shall comply with EMTALA in accordance with the Hospital's EMTALA Policy and Procedure.

HIPAA.

1. All members of the Medical Staff, Postgraduate Trainee Staff and Allied Health Professional Staff (and their respective employees and agents), shall maintain the confidentiality, privacy, security and availability of all protected health information (PHI) in records maintained by the Hospital in accordance with any and all health information privacy policies adopted by the Hospital to comply

with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). PHI shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the Hospital.

2. All members of the Medical Staff, Postgraduate Trainee Staff and Allied Health Professional Staff shall cooperate with Hospital personnel in obtaining and maintaining in the medical record any and all patient authorizations required under any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, HIPAA.

Mass Casualties and Disaster Response

Mass Casualties and Disaster Response. A “disaster”, for the purpose of the Hospital/Northwell, is an event or situation that disrupts or overwhelms the resources of the facility or staff in providing medical care. This may take the form of an external event such as a transportation accident with large numbers of victims, or an internal event such as a flood or utility disruption that closes part of the facility. The Medical Staff plays an integral role in the institution’s plan to respond to these situations.

Preparation. The Mass Casualties and Disaster Committee reports to the Medical Board. Its membership includes physician and non-physician representatives from many departments and divisions including medicine, emergency medicine, surgery, psychiatry, nursing, pharmacy, administration, security, engineering, materials operations, and others that reflect the institution-wide impact of a disaster. The committee meets regularly to discuss contingency plans for a wide range of emergencies such a terrorist incident, nuclear exposure, or telephone outage. The committee maintains the facility’s emergency management plan, organizes drills, and critiques these drills and actual activations of the plan.

Response. The emergency management plan is based on the Hospital Emergency Incident Command System (HEICS). HEICS features a logical management structure with forty-nine positions grouped into one of four sections. The cornerstone of HEICS is 1) a clear division of tasks, 2) a defined set of responsibilities for each manager, and 3) a set of common terminology to enhance communication and improve documentation. The aim of the model is to improve accountability, efficiency, and communication within the hospital and with other emergency responders. It also provides a framework for critique and is flexible enough to allow experience-based enhancements.

Role of the Medical Staff during an Emergency. The medical staff is an essential part of the hospital’s disaster response capability. If an emergency is declared, the chief medical officer in the HEICS command structure will decide whether and which full-time and voluntary generalists and specialists are needed to assist with medical care based on the

number and type of casualties. It is requested that the medical staff bear in mind the following:

- Maintain and regularly update contact information with 1) your Department Head, 2) the Medical Staff Office, and 3) your housestaff. Home, mobile, pager, office, and fax numbers should be available.
- If a disaster occurs in the region, stay within reach should your assistance be requested.
- If you are able and willing to assist during a disaster, contact your Department Head for further instructions prior to contacting the command center or the ED or coming to the hospital. This will prevent confusion and misallocation of resources.
- If evacuation or transfer of inpatients from the facility becomes necessary during an emergency, be able to assist in this process and plan for continuing care.
- Physicians may call the staff information hotline (562-INFO) for a recorded message and instructions during an emergency.

Adoptions. No physician shall, by himself, undertake the placement of a child for adoption without the involvement of the Department of Social Work. Involvement in non-agency adoptions in which physician remuneration is above and beyond the usual and customary obstetric fee for newborns delivered at the Hospital will be cause for dismissal from the Medical Staff.

K. SUPERVISION OF THE POSTGRADUATE TRAINEE STAFF

1. Postgraduate Trainees are given patient care responsibilities commensurate with their individual level of training, credentialing, experience and capability as determined by the Chair of the respective clinical departments. In all matters of an individual patient's care, the attending physician is always responsible for the performance of residents. History and physical examinations, daily visits, orders, progress notes, or other assigned medical care responsibilities performed by residents does not preempt the attending physician's ultimate responsibility for the care of each patient.
2. Supervision must be provided by physicians who are board certified or admissible in those respective specialties or who have completed a minimum of four (4) postgraduate years of training in such specialty. There shall be a sufficient number of such supervising physicians present in person in the Hospital twenty-four (24) hours per day, seven (7) days per week to supervise the Postgraduate Trainee Staff and to meet reasonable and expected demand. When it can be documented that the patient's attending physician is immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by members

of the Postgraduate Trainee Staff who are in their final year of post-graduate training, or who have completed at least three (3) years of post-graduate training.

3. The attending is responsible to ensure that all decisions and determinations as to patient care are reflected in the treatment plan as written in the progress notes of the patient's medical record. The treatment plan is the written vehicle through which communication among those attendings and the Postgraduate Trainees involved in the patient's care is enabled. Therefore, all relevant information must be clearly and thoroughly documented. The following additional requirements apply to treatment plans:

- a) The treatment plan and any significant modifications must be approved by the attending. This approval shall be documented in the patient's medical record.
- b) The treatment plan must be reviewed in accordance with the patient's condition and can only be amended by the written authorization of the attending. A Postgraduate Trainee may only amend the treatment plan without consulting with the responsible attending when the Postgraduate Trainee determines that an emergency exists. The amendment must be documented in the medical record and the attending notified as soon as possible.
- c) In the event that the attending will not be available for a given period of time, (i.e., the weekend), the attending must document the following in the progress notes:
 - i. the name of the physician/dentist who will be covering in the attending's absence and who will, therefore, be responsible for supervising the patient's care; and
 - ii. a statement confirming that both the patient and the Postgraduate Trainee caring for the patient have been informed of the name of the covering physician/dentist.

This provision shall not apply to members of a formal, established medical group practice as recorded in the Medical Staff Office which routinely provides for on call coverage of the group's patients by the members of such group.

- d) The covering attending who is temporarily responsible for the direct supervision of the patient's care must assume all of the duties of the attending physician/dentist and must document the following in the progress notes:
 - i. all relevant patient care data and/or amendments to the treatment plan; and
 - ii. at the conclusion of the period of coverage, the covering attending/dentist must document that all pertinent information regarding

the patient's care and status has been relayed to the primary attending upon that attending's resumption of the care of the patient.

4. Supervision by an attending surgeon of the care provided to surgery patients by Postgraduate Trainees must be documented and include at least the following:
 - a) personal supervision of all surgical procedures performed by Postgraduate Trainees requiring general anesthesia or an operating room procedure;
 - b) pre-operative examination and assessment by the attending surgeon; and
 - c) daily post-operative examination and assessment by the attending surgeon.
5. Within the context of the graduate medical education training program, documentation in the patient's medical record shall reflect the following requirements:
 - a) When surgery or high risk procedures are performed by Postgraduate Trainees, documentation by the attending surgeon in the medical record must reflect that the attending surgeon was physically present during the key portion of the performance of the surgery or high risk procedure. Documentation must also reflect that the attending surgeon was immediately available to furnish services during the entire surgery or procedure.
 - b) When endoscopic procedures are performed by Postgraduate Trainees in a teaching setting, the attending physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device, and the documentation in the medical record by the attending physician must reflect this fact.
 - c) When radiologic procedures are performed by postgraduate trainees, documentation must reflect that the physician personally performed the interpretation of the test or reviewed the postgraduate trainee's interpretation with the Postgraduate Trainee. Countersignature is not adequate documentation of attending physician supervision.
6. The Program Directors of the Hospital's Graduate Medical Education programs are responsible for:
 - insuring compliance by Medical Staff members with the supervision requirements of these Rules and Regulations and with the Regulations applicable to supervision of Postgraduate Trainees;
 - monitoring the quality and appropriateness of patient care services provided by Postgraduate Trainees according to their level of training;
 - directing corrective measures or disciplinary actions with Postgraduate Trainees; and

- remaining continuously responsible and accountable to the Department Chair for all aspects of the Graduate Medical Education Program.

Any questions regarding this Section K should be referred to the appropriate Department Chair.

L. HOME CARE PROGRAM

1. Medical Staff members are expected to refer their patients who may need social service assistance, alternate level of care placement or home care assistance to the Care Coordination Department.
2. A written plan of care shall be developed for each patient who is a candidate to receive home care services after hospital discharge. This plan will be based upon assessment of the patient's post hospital care needs by the Hospital's discharge planning staff and the physician who has primary responsibility for the patient.
3. During the patient's hospital stay, this plan shall be periodically re-evaluated by staff in collaboration with the patient's primary physician. The essentials of the written plan of care shall be made part of the patient's medical record.
4. Patients may choose to receive home care services from a provider other than the Hospital's Home Care Department for reasons of preference, insurance coverage, or residence outside of the Home Care Department's catchment area. The assigned clinical care coordinator shall make the necessary home care arrangements to reflect the patient's choice.
5. After the patient is discharged from the Hospital into a home care program, a visiting nurse shall maintain regular contact with the primary physician to report on the patient's progress. The primary physician, in consultation with the home care staff, shall be responsible for the home care services plan and for the decision to discharge the patient from home care. Additionally, the primary physician will collaborate with the home care staff to develop a post home care plan when home care services are terminated.

M. MISCELLANEOUS HOSPITAL AND PATIENT CARE REGULATIONS

1. PATIENT RIGHTS

Consistent with the hospital's policy of respect for the individuality and dignity of patients, the Medical Staff endorses the "Patients Bills of Rights" which have been promulgated by the NY State Department of Health and NY State Office of Mental Health.

The use of restraints or the placement of a patient in seclusion may only be accomplished by physician order. The order must be written to comply with Patient Care policies and

procedures, where applicable, and the policies and procedures promulgated by the Department of Psychiatry.

Except for patients in the Department of Psychiatry, no patient shall be permitted to leave the Hospital on pass.

2. **ENVIRONMENT OF CARE**

The Hospital has been designated as a “Smoke Free” hospital. All members of the Medical Staff shall observe the rules of the Hospital in regard to “No Smoking”.

3. **ETHICS**

The primary mechanism to address patients’ and staff needs for resolution of issues relating to the ethical and caring treatment of the patient shall be with the responsible Medical Staff member in consultation with the patient and/or family and, when necessary, with his or her Department Chair. Additional counsel of the Ethics Committee may be sought at the discretion of the Medical Staff member or Department Chair via the “Ethics on Call” mechanism.

No physician shall be required to give advice regarding pregnancy prevention and/or termination of pregnancy nor shall the physician be required to participate in the performance of this procedure. However, the physician shall be required to assist in transferring the patient to another physician who will provide the requested care.

4. **DEATH/AUTOPSY**

When a patient expires, the patient shall be pronounced dead by the attending physician or designee. The attending physician, or designee, is responsible for making the appropriate entry in the patient’s medical record and for notifying the next of kin. If the attending physician, or designee, is unable to contact the next of kin, the attending physician shall follow the procedure set forth in the applicable Northwell policy. In accordance with applicable law and Northwell policy, the attending physician or a practitioner designated by the attending physician must complete the death certificate.

It shall be the duty of all Medical Staff members to attempt to obtain permission for an autopsy in all deaths except:

- when an autopsy is legally prohibited;
- when a patient’s known wishes prohibit autopsy; or
- when a patient’s known religion prohibits autopsy.

An autopsy can only be performed after appropriately obtained informed consent. In Medical Examiner cases consent for hospital performed autopsy can only be obtained after the Medical Examiner has released jurisdiction. A notation should be made in the medical record whether or not permission for an autopsy was obtained.

N. PROFESSIONAL LIABILITY INSURANCE

All members of the Medical Staff must procure and maintain professional liability insurance in the amount that satisfies the minimum amount required by the Board of Trustees for the duration of their association with the Hospital. Professional liability insurance must be purchased from a carrier and policy form acceptable to the Board of Trustees. All Medical Staff members must provide to the Hospital and the Medical Staff Services Central Office a Certificate of Insurance acceptable to the Board of Trustees. All Medical Staff members must immediately inform the Hospital of any change, suspension, lapse or termination of professional liability insurance. Failure to maintain mandated professional liability insurance will result in automatic suspension of Medical Staff Privileges. If a Medical Staff member seeks a Leave of Absence for any reason and intends to change, suspend or terminate Professional Liability insurance during the leave a request must be made in writing and approved by the Credentials Committee at least 30 days prior to commencement of the Leave of Absence. If the professional liability is written on a claims made basis, an extended reporting period (“tail”) must be obtained for the leave of absence or at any time that the policy is terminated. Professional liability insurance must be reinstated prior to return from Leave of Absence.

O. CORRECTIVE ACTION PROCEDURES FOR MEDICAL STAFF

Except as provided otherwise elsewhere in the Medical Staff Bylaws and these Rules and Regulations, the procedures set forth in this Section O shall apply whenever corrective action has been requested under Article VIII of the Medical Staff Bylaws.

1. REQUEST FOR HEARING.

- a) A practitioner who has received notice of a request for corrective action as set forth in Subsection 8.1.2(A)(vii) through (xi) of Article VIII of the Medical Staff Bylaws, notice of summary action, or an adverse recommendation on an application for appointment or reappointment to the Medical Staff, and who desires a hearing before a Hearing Committee with respect to such request, action or recommendation, shall do so by submitting a written request for a hearing to the Chair of the Medical Board. Such written request shall be submitted by overnight delivery service or personal delivery within thirty (30) days of his/her receipt of notice of the request, action or recommendation. If the practitioner fails to request a hearing within such time limitation, or to appear at the time set for the hearing, he or she shall be deemed to have waived the right to a hearing, as set forth in Subsection 8.1.6 of the Medical Staff Bylaws.
- b) If a Medical Staff member is subject to corrective action at both the Hospital and one or more other Northwell Hospital(s) where he/she also has clinical privileges, and the corrective actions at the hospitals are based on substantially the same facts, then the practitioner shall be entitled to request one (1) hearing, the final determination of which shall apply at all the hospitals. The hearing and any appeal therefrom shall be requested at, and shall be conducted in accordance with the

Medical Staff Bylaws and the Rules and Regulations of the hospital where the principal facts occurred. If the principal facts occurred at a non-hospital location or at more than one hospital, the hearing shall be requested at the hospital designated by the practitioner as his/her primary hospital in his/her most recent application for appointment or reappointment. All issues relating to the corrective action at all hospitals shall be presented at the hearing and any subsequent appeal.

2. CHALLENGES TO THE COMPOSITION OF THE HEARING COMMITTEE. Any challenge by the practitioner to any member of the Hearing Committee pursuant to Subsection 8.1.5 shall be made in writing to the Chair of the Hearing Committee no less than fifteen (15) days prior to the date of the Hearing. If the challenge is regarding the Chair of the Hearing Committee, it shall be made by the practitioner to the Executive Director of the Hospital.

3. CONDUCT OF THE HEARING.

a) Not less than five (5) business days prior to the hearing, the practitioner and the Hospital shall simultaneously exchange (i) a list of witnesses, including experts, that each intends to call at the hearing, together with a brief statement describing the subject matter of each witness' testimony and the relevance thereof to the issues in the hearing; and (ii) copies of all exhibits that they propose to introduce as evidence at the hearing. If necessary, such exchange may be supervised by the Chair of the Hearing Committee. Thereafter, neither party may call any additional witness or offer any additional exhibit without the permission of the Chair of Hearing Committee upon a showing of good cause as to why the witness or exhibit could not have been identified prior to the start of the hearing, such as, for example, where rebuttal evidence is offered to respond to the practitioner's evidence. The exchange of witness lists and exhibits shall be without prejudice to either party's right to object to a witness or exhibit at any time on any proper ground. If feasible, however, such objections should be stated and resolved prior to the start of the hearing. Prior to the exchange of the witness lists and exhibits as described above, the practitioner and the Hospital shall enter into a written and signed agreement, in form and substance satisfactory to the Hospital, that ensures the protection of the confidentiality of all quality assurance, peer review and protected health information used by either party in the course of the hearing and any subsequent internal Hospital reviews and appeals and administrative or judicial proceedings.

b) In consideration of the sensitive nature of the physician-patient relationship, neither the practitioner nor the Hospital may call a patient, past or present, to testify on his/her or its behalf at the hearing, or offer as evidence any written or oral patient statement solicited or obtained for the purposes of the hearing. A statement shall not be deemed to have been solicited or obtained for the purposes of the hearing if the statement caused, in whole or in part, the corrective action, or

was obtained in the course of investigating whether corrective action should be requested or taken.

- c) Witnesses may be permitted to testify remotely only upon a showing of good cause as to why the witness is unable to be present and a determination by the Chair of the Hearing Committee that such remote testimony will not unfairly prejudice the other party or impede the Hearing Committee's ability to evaluate the testimony. Remote testimony shall not be permitted if (i) the witness is to be examined or cross-examined with respect to the content or authenticity of documents and/or images, or (ii) video of the witness is not available, unless the Chair determines that the absence of video would not unfairly prejudice the other party or impede the Hearing Committee's ability to evaluate the testimony. When remote testimony is permitted, it shall be the obligation of the party calling the witness to make all technological arrangements, and bear the expense thereof, as may be necessary for the transmission, receipt and broadcast of the testimony in a manner that ensures that all participants in the hearing are able to hear and view (unless the Chair determines that video is not required) the witness.
- d) The practitioner must be present at the hearing, and, subject to the limitations set forth in paragraphs a), b) and c) above, both the practitioner and the Hospital shall be entitled to present relevant evidence and witnesses on his/her or its behalf, to question witnesses appearing on behalf of the other party, and to submit a written statement following the close of the hearing; provided, however, that neither the practitioner nor the Hospital may present a patient as a witness at the hearing. A record of the hearing shall be made by such method as shall be determined by the Chair of the Hearing Committee. Such hearing shall not be open to the public and documents and testimony shall be maintained in strict confidence by all participants and witnesses, consistent with Article 28 of the Public Health Law. The hearing shall not be subject to any formal rules of evidence or procedure, and the Hearing Committee may permit the presentation of evidence and witnesses subject to such restrictions and limitations as it may impose and as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. There shall be no right to pre-hearing discovery. Rulings with respect to evidence and witnesses shall be made by the Chair of the Hearing Committee. A majority of the members of the Hearing Committee shall constitute a quorum. The practitioner and the Hospital each may elect to be represented at the hearing by legal counsel. At its option, the Hearing Committee also may be advised by legal counsel, provided that the attorney appointed to advise the Hearing Committee is not the same attorney as the attorney representing the Hospital before the Hearing Committee. The Hearing Committee, through its Chair, shall make such additional rules as it deems necessary to ensure a fair and expeditious handling of the matter. Following the conclusion of the Hearing, both parties may submit simultaneously a written statement to the Hearing Committee.

4. APPELLATE REVIEW COMMITTEE. If a practitioner requests appellate review pursuant to Subsection 8.1.8 of the Medical Staff Bylaws, the Board of Trustees shall appoint an Appellate Review Committee composed of three (3) members of the Board of Trustees. A Chair of the Appellate Review Committee shall be appointed by the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as that person did not request the corrective action or otherwise take part in a prior proceeding on the same matter. For purposes of the appellate review, both parties shall have access to the recommendation and record of the Hearing Committee, the decision of the Medical Board, and all other material that was considered by the Hearing Committee in making its recommendation, unless any such material is otherwise exempt from disclosure by law.

5. APPEAL PROCESS. Unless the Chair of the Appellate Review Committee authorizes a different schedule, the party requesting appellate review shall submit his/her or its written statement setting forth in full the grounds for the appeal and the reasons in support thereof to the Appellate Review Committee and to the opposing party within twenty (20) days after the date of receipt by the Board of Trustees of the request for appellate review. The opposing party shall submit a responsive statement within twenty (20) days of receipt of the appealing party's statement. After receiving both statements, the Chair of the Appellate Review Committee shall schedule a date, time and place for the appellate review and shall give written notice of the schedule to the parties. The date of the appellate review shall not be more than twenty (20) days from the date that the Appellate Review Committee received the opposing party's statement, unless agreed to by the Chair of the Appellate Review Committee and all parties. The Appellate Review Committee shall review the record created at the Hearing Committee, the statement of appeal, and the responsive statement for the purpose of determining whether the decision of the Medical Board had a rational basis. The Chair of the Appellate Review Committee may, in his or her sole discretion, allow oral argument or accept additional written evidence, subject to a foundational showing that such evidence could not have been made available at the hearing in the exercise of reasonable diligence. New or additional matters not raised at the hearing, nor otherwise reflected in the record, shall not be introduced at the appellate review unless the Appellate Review Committee, in its sole discretion, decides to consider such new matters.

6. SUMMARY ACTION AND PROCEEDINGS.
 - a) Notice of a summary suspension or restriction of a practitioner's clinical privileges shall be given to the practitioner personally or sent by overnight delivery service as soon as practicable.

 - b) If the Medical Director imposes summary action, then he/she shall designate an alternate to perform his/her functions under Subsection 8.21 of the Medical Staff Bylaws. If the Chair of the Medical Board imposes summary action, then the Medical Director shall assume the duties of the Medical Board Chair in the

remainder of the corrective action process, including but not limited to convening the summary action review committee.

- c) In the event the summary action review committee recommends by unanimous vote that the summary action should be terminated, the individual who imposed the summary action may elect to recommend a different corrective action, which will then proceed in accordance with Article VIII of the Medical Staff Bylaws and paragraphs 1-5, above, of this Section O of these Rules and Regulations.
 - d) In the event the summary action review committee supports the summary action recommendation, the person who first imposed the summary action shall submit a written request for summary corrective action, stating the facts upon which the summary action was based, to the Chair of the Medical Board with a copy given to the practitioner personally or sent by overnight delivery service. The request for corrective action may be supplemented by providing further information to the Chair of the Medical Board at any time but not less than fifteen (15) days prior to the scheduled date of the hearing, if one has been requested. A copy of the additional information submitted to the Chair of the Medical Board shall be given to the practitioner personally or sent by overnight delivery service or personal delivery as soon as practicable. All further proceedings on the written request for corrective action, including the hearing procedures to be afforded the affected practitioner, shall be in accordance with Article VIII of the Medical Staff Bylaws and the provisions of paragraphs 1-5, above, of these Rules and Regulations.
7. WITHDRAWAL OF CORRECTIVE ACTION. Any request for corrective action, including a summary action, may be withdrawn by the person requesting or imposing it at any time prior to the consideration of the matter by the Hearing Committee. Notice of such withdrawal shall be provided to the affected practitioner by the person or body withdrawing it.
8. ALTERNATE MEDICAL COVERAGE. Immediately upon any termination, limitation or suspension of a practitioner's Medical Staff membership or any termination, limitation or suspension of his or her clinical privileges, either under Article III or Article VIII of the Medical Staff Bylaws and this Section O of the Rules and Regulations, the Department Chair, Chair of the Medical Board, the Medical Director, or the Executive Director of the Hospital shall each have authority to arrange for alternate medical coverage for the practitioner's patients still in the Hospital. The wishes of the patients concerned shall be considered in the selection of an alternate practitioner.

P. CORRECTIVE ACTION PROCEDURES FOR ALLIED HEALTH PROFESSIONAL STAFF

1. REQUEST FOR CORRECTIVE ACTION.

- a) A request for corrective action may be made with regard to any member of the Allied Health Professional Staff whenever his or her conduct, condition, professional or otherwise, is considered to be inconsistent with the Hospital's standards of patient care, patient welfare or the objectives of the Hospital; if such conduct or condition reflects adversely on the Hospital or the character or competence of such Allied Health Professional Staff member; or results in disruption of Hospital operations. A request for corrective action also may be made with regard to any Allied Health Professional Staff member who fails to comply with any of the Medical Staff Bylaws, these Rules and Regulations, the Corporate Bylaws, or any rules, regulations or policies of the Board of Trustees. A request for corrective action may be made with regard to such Allied Health Professional Staff member to the Chair of the Medical Board by the Chair of the Department to which the Allied Health Professional Staff member is assigned, or to the Hospital's Executive Director.
- b) The request for corrective action may include, without limitation, a recommendation of the restriction, suspension, or termination of the Allied Health Professional Staff member's clinical privileges. Such request for corrective action shall be in writing and shall set forth the facts upon which it is based.

2. NOTICE.

- a) The Chair of the Medical Board shall ensure that a copy of the request for corrective action is sent by overnight delivery service or personal delivery to the Allied Health Professional Staff member as soon as may be practicable under the circumstances. At the same time, the affected Allied Health Professional Staff member shall be advised of his or her right to appear before an Allied Health Professional Staff Review Committee at which the request for corrective action will be presented for consideration, which shall not be less than fifteen (15) days following the date on which the notice thereof is personally delivered or sent by overnight delivery service to the Allied Health Professional Staff member, and he or she requests that such Committee be formed. Absent such a request by the Allied Health Professional Staff member, the recommendation for corrective action will be transmitted to the Medical Board and then to the Board of Trustees for final action. The Allied Health Professional Staff member may submit a written statement of his or her position to the Allied Health Professional Staff Review Committee provided that the statement is received by the Committee not less than five (5) days prior to the date of the Committee meeting.

- b) If an Allied Health Professional Staff member is subject to corrective action at both the Hospital and one or more other Northwell hospital(s) where he/she also has clinical privileges, and the corrective actions at the hospitals are based on substantially the same facts, then the practitioner shall be entitled to request an appearance before one (1) Allied Health Professional Staff Review Committee, the final determination of which shall apply at all the hospitals. The Committee meeting and any subsequent appeal shall be requested at, and shall be conducted in accordance with the Allied Health Professional Staff provisions of the Medical Staff Bylaws of the hospital where the principal facts occurred. If the principal facts occurred at a non-hospital location or at more than one hospital, the meeting shall be requested at the hospital designated by the practitioner as his/her primary hospital in his/her most recent application for appointment or reappointment. All issues relating to the corrective action at all hospitals shall be presented at the meeting and any subsequent appeal.
3. ALLIED HEALTH PROFESSIONAL STAFF REVIEW COMMITTEE. An Allied Health Professional Staff Review Committee shall be appointed by the Chair of the Medical Board to review a request for corrective action made with respect to an Allied Health Professional Staff member. At the meeting of the Allied Health Professional Staff Review Committee, the Committee shall inquire into and take action on the request for corrective action. The Allied Health Professional Staff Review Committee shall consist of (i) the Hospital's Medical Director, who shall Chair this Committee, (ii) an Attending physician not a member of the Department to which the Allied Health Professional Staff member is assigned, and (iii) a member of the Allied Health Professional Staff from the same discipline. The Allied Health Professional Staff member shall be permitted to appear before the Committee prior to its taking any action provided that a written statement requesting such an appearance is received by the Committee not less than five (5) days prior to the date of the Committee meeting. Failure of the Allied Health Professional Staff member to appear shall be deemed a waiver of any such privilege at such meeting and during any subsequent proceedings under these Bylaws. Such proceedings may be adjourned, at the discretion of the Chair of the Committee, or they may be continued to a subsequent meeting if, in the judgment of the Chair of the Committee, adequate consideration cannot be given to the request for corrective action at one meeting or further information or evidence with respect to the Allied Health Professional Staff member needs to be obtained. No later than five (5) days prior to the scheduled meeting, the Allied Health Professional member may request in writing to the Chair of the Committee that he or she be represented by legal counsel during his or her appearance before the Committee. If the Allied Health Professional Staff member is to be represented at the Committee meeting by legal counsel, the Department shall be represented by legal counsel as well. A record of the committee meeting shall be made by such method as shall be determined by the Chair of the Allied Health Professional Review Committee. The proceedings shall not be subject to any formal rules of evidence or procedure, and the Chair may permit the presentation of witnesses and other evidence subject to such restrictions and limitations as he or she may impose. Rulings with respect to evidence and witnesses shall be made by the Chair.

4. ALLIED HEALTH PROFESSIONAL STAFF REVIEW COMMITTEE ACTION AND NOTICE OF DECISION. The Allied Health Professional Staff Review Committee may accept, reject or modify the request for corrective action, or take any other action that the Committee deems appropriate under the circumstances. The Review Committee shall issue a written report setting forth its decision and the reasons therefor. A copy of the Review Committee's report shall be given to the Allied Health Professional Staff member, the Department Chair and the Medical Board within fifteen (15) days after the Committee's report is written.
5. RIGHT OF APPEAL. If the Allied Health Professional Staff Review Committee upholds the recommendation of corrective action, the Allied Health Professional Staff member may request an appeal of the matter before the Executive Director, or his/her designee if the Executive Director is the person recommending the corrective action. The person who recommended corrective action also may request an appeal if the Committee does not uphold the recommendation. Any appeal requested shall be submitted to the Medical Director in writing and within ten (10) days of the Allied Health Professional Staff member's receipt of the decision of the Allied Health Professional Staff Review Committee. Upon receipt of the request for an appeal, the Executive Director will review the Allied Health Professional Staff member's record, the basis of the request for corrective action and the Allied Health Professional Staff Review Committee's report and decision. The Executive Director may request and consider any additional information that he/she deems necessary. Upon completion of this review, the Executive Director will notify the Allied Health Professional Staff member, the Department Chair, the Medical Director and the Medical Board of his/her decision in writing within ten (10) days of the issuance of his/her decision. The decision of the Executive Director will be final and binding upon all parties, subject only to final action by the Board of Trustees. Failure by the Allied Health Professional Staff member or the person who recommended corrective action to request an appeal within the time frame set forth in this paragraph shall be deemed a waiver of the right of any further appeal of this matter, and the decision of the Allied Health Professional Staff Review Committee shall be deemed conclusive and final, subject only to final action by the Board of Trustees.
6. FINALITY OF ACTION. Decisions of the Executive Director shall be transmitted to the Board of Trustees for final action. There shall be no further Hospital proceedings.
7. SUMMARY SUSPENSION OR RESTRICTION ("SUMMARY ACTION") AND PROCEEDINGS. The appointment and/or privileges granted to a member of the Allied Health Professional Staff may be summarily suspended or restricted in accordance with the following:
 - a) A Department Chair or his or her Designee, the Medical Director and the Executive Director of the Hospital each shall have the authority, whenever action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations to summarily suspend or restrict all or

any portion of the appointment and/or privileges granted by the Hospital to a member of the Allied Health Professional Staff. Any member whose appointment or privileges are so suspended or restricted shall be given notice of such summary action, and the reason or reasons therefor, by overnight delivery service or personal delivery as promptly as shall be practicable under the circumstances. Any such summary action shall be effective immediately.

- b) Within five (5) days of the summary action, a written request for corrective action stating the facts upon which the Allied Health Professional Staff member's summary action was based shall be filed with the Chair of the Medical Board by the person(s) directing the summary suspension and a copy shall be given to the Allied Health Professional Staff member by overnight delivery service or personal delivery. Thereafter, all further proceedings on the written request for corrective action shall be in accordance with the provisions of paragraphs 1 through 6 above. In the event that the proceedings before the Allied Health Professional Staff Review Committee are adjourned in accordance with paragraph 3 above, then, upon the request of the Allied Health Professional Staff member, the Allied Health Professional Staff Review Committee shall consider the need for the immediacy of the Allied Health Professional Staff member's summary suspension or restriction at its initial meeting.
 - c) A summary action may be withdrawn by the committee or person imposing the same at any time prior to a meeting of the Allied Health Professional Staff Review Committee.
9. DUTY OF COOPERATION. It shall be the duty of each member of the Allied Health Professional Staff to cooperate fully with all proceedings in which he or she is involved. Failure or refusal of a member at any time to do so shall be cause for suspension, summary or otherwise, termination, or limitation of all or part of his or her clinical privileges and Allied Health Professional Staff membership. Furthermore, by accepting membership on the Allied Health Professional Staff, each member thereby agrees that he or she will take no action against the Hospital or any representatives of the Hospital or its Medical, Graduate or Nursing Staff, or against any person supplying information or evidence thereto, for acts performed or statements made in good faith and without malice in connection with any proceedings provided for in the Medical Staff Bylaws and these Rules and Regulations.

Q. STANDING COMMITTEES OF THE MEDICAL BOARD – MEMBERSHIP

- 1. GENERAL. The Chair of the Medical Board shall, after consultation with the President of the Medical Staff, appoint the Chairs of the Standing Committees and the members thereof, unless such appointments are otherwise provided for in the Medical Staff Bylaws or hereafter. However, the Chair of the Medical Board may, at his or her discretion, delegate responsibility for appointment of committee members to the Committee Chairs.

2. **THE MEDICAL ETHICS COMMITTEE.** The Medical Ethics Committee shall consist of a minimum of ten (10) members of the Hospital staff, including members of the Medical Staff, Allied Health Professional Staff, Postgraduate Trainee Staff, Department of Nursing and Administration. The Medical Director serves as an ex officio member of the Committee. Additional members may be appointed by the Chair of the Medical Board, as necessary.
3. **MEDICAL STAFF AFFAIRS COMMITTEE (“PHYSICIANS’ FORUM”).** The Medical Staff Affairs Committee shall be comprised of the President, President-Elect, Secretary, Treasurer and Immediate Past President of the Medical Staff, two representatives from each of the Clinical Departments of the Hospital, the Executive Director, Nurse Executive, Chair of the PICG, and a representative from the Hospital’s Department of Quality Management. The Committee will be co-chaired by the President of the Medical Staff and the Executive Director.

R. STANDING COMMITTEES OF THE SYOSSET CAMPUS

Unless otherwise specified in the Medical Staff Bylaws, the membership of the Standing Committees of the Syosset Campus and their Chairs shall be as set forth hereafter:

MEDICAL ETHICS COMMITTEE

The Medical Ethics Committee shall be multidisciplinary and composed of members interested in the ethical dimensions of medicine and patient care and can include physicians, administrators, legal counsel, nurses, social workers and clergy. The Chair of the Leadership Coordinating Council shall appoint representatives of the Medical Staff to the Ethics Committee.

THE MEDICAL STAFF HEALTH COMMITTEE (MSHC)

The MSHC shall be comprised of at least three (3) voting members, who shall be the Medical Director and such other voting or non-voting members (which may include, without limitation, one (1) or more psychiatrists appointed by the Chair of the Leadership Coordinating Council, as appropriate, to address the particular condition or concerns with respect to the affected practitioner. The Committee is part of the Hospital’s quality assurance/performance improvement and malpractice prevention program, and its members shall have the legal immunity associated with that program.

THE PERFORMANCE IMPROVEMENT COORDINATING GROUP (PICG)

The PICG shall consist of at least one representative from each clinical department and shall be chaired by a physician. Other appropriate administrative and staff members may be appointed as required, which may include representatives from the Administrative, Medical, Nursing and Ancillary Support Staff, as appropriate, as well as the Director of Quality Management, the Patient Representative, the Safety Officer, Risk Management, and a representative from the Northwell Quality Management Department.

S. OPERATIONAL COMMITTEES OF THE HOSPITAL

The Operational Committees are Hospital committees charged with developing and recommending policies and procedures governing various operational functions and practices. The individual Operational Committees and their areas of responsibility are as set forth below. Each Campus may have its own Operational Committees. The chairmen and members of the Operational Committees at each Campus shall be as set forth below, and shall be appointed in accordance with Subsection 6.1.3.1(G) of the Medical Staff Bylaws, except that at the Syosset Campus they shall be appointed by the Executive Director and Medical Director of the Syosset Campus.

1. OPERATIONAL COMMITTEES IDENTIFIED. The individual Operational Committees of the Hospital shall be as follows:

- The Cancer Committee (Manhasset Campus only)
- The Critical Care Committee (Manhasset Campus only)
- The Emergency Management Committee
- The Health Information Management Committee
- The Infection Prevention and Control Committee
- The Nutrition Committee (Manhasset Campus only)
- The Perioperative Executive Council (Manhasset Campus only)
- The Pharmacy and Therapeutics Committee
- The Professional Library Committee
- The Radiation Safety Committee
- The Tissue Committee
- The Transfusion Committee

2. MEMBERSHIP AND FUNCTIONS OF THE OPERATIONAL COMMITTEES. The Operational Committees of the Hospital shall have the membership and functions, and shall conduct meetings as set forth hereafter:

CANCER COMMITTEE (MANHASSET CAMPUS ONLY)

A. MEMBERSHIP

This is a multidisciplinary committee with representation from the medical specialties and allied health professions involved in the care of patients with cancer.

The Committee shall consist of at least ten (10) members of the Medical Staff representing the disciplines of Gynecology, Medicine, Surgery, Medical Oncology, Radiation Medicine, Surgical Oncology, Pediatric Oncology, Radiology, Pathology and Laboratory Medicine, as well as other Departments and/or Divisions, as necessary; representatives of the Allied Health Professional Staff involved in the care of cancer patients; at least one (1) representative of the Postgraduate Trainee Staff; and members of

Administration, the Department of Nursing, the Cancer Registry, the Department of Social Services, and Quality Management. All physician members must be board-certified by their respective ABMS or AOA Specialty Board.

B. FUNCTIONS

The Cancer Committee is responsible for:

1. Planning, initiating, and assessing and reporting at least annually on all cancer related activities.
2. Providing guidelines for consultative services to cancer patients, evaluating the quality of care to these patients, developing and evaluating educational and research programs, and supervising activities of the Tumor Registry.
3. Maintaining and reviewing data on improving the performance of the cancer program as a whole.
4. Maintaining liaison with other pertinent committees of the Medical Staff as well as with State and local elements of the American Cancer Society, the New York State Department of Health and with the Department of Professional Services of the American College of Surgeons and its Committee on Cancer.
5. Maintaining compliance with the American College of Surgeons Commission on Cancer requirements for cancer committees.
6. Reporting regularly into the PICG and into the Medical Board, as necessary.

C. MEETINGS

The Committee shall meet at least quarterly and as many additional times as the Chair, thereof, shall direct.

CRITICAL CARE COMMITTEE (MANHASSET CAMPUS ONLY)

A. MEMBERSHIP

The Critical Care Committee shall consist of members of the Medical Staff representing the Departments of Medicine, Surgery, Pediatrics, Anesthesiology, Emergency Medicine, and other Departments and/or Divisions, as necessary. The Directors of Nursing for Surgical/Medical Critical Care and Cardiac Services, as well as a member of the Postgraduate Trainee Staff, also shall be members.

B. FUNCTIONS

The Critical Care Committee shall be concerned with the activities of all Critical Care Units and shall:

1. Periodically review and evaluate the functioning of these clinical areas including policies and procedures, staffing patterns, equipment, etc.
2. Evaluate and ensure that proper quality management programs are in place and report such activities to the PICG.
3. Evaluate and ensure that continuous Critical Care training programs are implemented.
4. Participate in any area-wide patterns of provision of Critical Care to the community, when requested.
5. Submit reports to the PICG at least quarterly and to the Medical Board, as necessary.

C. MEETINGS

The Committee shall meet at least quarterly.

EMERGENCY MANAGEMENT COMMITTEE

A. MEMBERSHIP

The Emergency Management Committee shall consist of members of the Medical Staff, together with the Executive Director, or his/her designee, who shall be an ex-officio member thereof. The members shall include, at a minimum, representation from the following:

- Emergency Medicine
- Trauma Service (Manhasset Campus only)
- Nursing
- Maintenance/Engineering
- Security
- Community Relations
- Critical Care (Manhasset Campus only)
- Communications
- Postgraduate Trainee Staff (Manhasset Campus only)

B. FUNCTIONS

The Emergency Management Committee shall be actively responsible for:

1. The continuous updating and implementation of the Campus's Hospital Emergency Operations (Disaster) Plan covering the reception, treatment and disposition of mass casualties and/or victims of the disaster. The plan will be documented in the Hospital Emergency Operations (Disaster) Manual, which shall be subject to approval by the Medical Board at the Manhasset Campus and the Leadership Coordinating Council at the Syosset Campus.
2. Maintaining a permanent record of the Hospital Emergency Operations (Disaster) Plan, subject to yearly review and approval by the Medical Board at the Manhasset Campus and the Leadership Coordinating Council at the Syosset Campus.
3. Submitting an annual summary of Emergency Management Committee Activities for the previous year to the Medical Board at the Manhasset Campus and the Leadership Coordinating Council at the Syosset Campus.

C. MEETINGS

The Committee shall meet as often as necessary, but at least quarterly.

HEALTH INFORMATION MANAGEMENT COMMITTEE

A. MEMBERSHIP

The Committee shall be comprised of members of the Medical Staff, representing a cross-section of the clinical services, representatives from Nursing, and the Director of Health Information Management. Representatives from other Departments may be included, as necessary. At the Manhasset Campus, the Committee also may include representatives from the Postgraduate Trainee Staff.

B. FUNCTIONS

The Health Information Management Committee is responsible for:

1. Establishing and coordinating a process involving the medical and ancillary departments that meets the requirements of The Joint Commission (and all other applicable accrediting and certifying boards and bodies) and the New York State Department of Health for the review of medical records to assure appropriate clinical information is contained within the patient's chart.

2. Reviewing medical records for timely completion, clinical pertinence, overall completeness and adequacy for use in quality assessment activities.
3. Advising and recommending policies for medical record maintenance.
4. Making recommendations to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus, and to the PICG, whenever necessary or desirable, relative to any changes in the format of the medical record, as well as to its proper filing, indexing, storage, retention period and availability, together with any recommended rules and regulations in connections therewith.
5. Advising and developing policies, with the assistance of counsel, to guide the Medical Record Librarian, Medical Staff and Administration with respect to privileged communications and the legal release of information.
6. Reviewing the monthly rates of incomplete charts and working with the appropriate Department Chairs to develop corrective action plans to ensure the appropriate completion of such charts. It may recommend to the Department Chair/Director disciplinary action against members of the Staff who are chronically delinquent or deficient in attending to their medical records.
7. Submitting reports regularly to the PICG and as necessary to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus.
8. Maintaining a permanent record of all proceedings and recommendations.

C. MEETINGS

The Health Information Management Committee shall meet as often as necessary, but at least six (6) times annually at the Manhasset Campus and at least quarterly at the Syosset Campus.

INFECTON PREVENTION AND CONTROL COMMITTEE

A. MEMBERSHIP

At the Manhasset Campus, the Infection Prevention and Control Committee shall consist of members of the Active Medical Staff, including the Hospital Epidemiologist, who will act as Chair, and representatives from Administration, Employee Health Service, Ambulatory Care Services, Nursing Department, Postgraduate Trainee Staff, Department of Laboratories, and the supervisor of the Operating Suite. The Committee may invite representatives, without vote, from the Dietary, Pharmacy, Central Service, Housekeeping, Laundry, and Engineering and Maintenance Departments.

At the Syosset Campus, the Infection Prevention and Control Committee shall consist of representatives from Administration, the Medical and Nursing Staffs, and other services. The Committee is chaired by a physician who has knowledge of and interest in epidemiology and infectious diseases. The Chair delegates authority to the infection control practitioners to carry out infection control measures.

B. FUNCTIONS

The Infection and Prevention Control Committee shall be responsible for the investigation, control, and prevention of infections within the Hospital and shall:

1. Maintain surveillance of Hospital infection potentials.
2. Identify and analyze incidents and causes of all infections.
3. Develop and implement a preventive and corrective program to minimize infection hazards.
4. Supervise infection control in all phases of Hospital activities.
5. Submit reports regularly to the relevant Campus's PICG and as necessary to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus.

C. MEETINGS

The Committee shall meet at least six times per year.

NUTRITION COMMITTEE (MANHASSET CAMPUS ONLY)

A. MEMBERSHIP

The Committee shall be comprised of at least twenty (20) members, including the Director of the Nutrition and Food Service Department, pediatric and adult nutrition support teams, and:

A representative from each of the following disciplines:

- Food and Nutrition Services (2 rotation members)
- Nursing
- Pharmacy
- Quality Management

- Administration
- Speech Pathology
- Postgraduate Trainee Staff

At least one (1) physician each from the following Departments/Divisions:

- Medicine
- Gastroenterology
- Oncology
- Endocrinology
- Critical Care Medicine
- Infectious Disease
- Nephrology
- Hematology
- Surgery
- Critical Care Surgery
- Pediatrics
- Neonatal Intensive Care
- OB/GYN
- Neurology

A member of the Postgraduate Trainee Staff as a non-voting member.

A member of the Medical Staff with specialized expertise, training and active Board Certification in Nutrition shall serve as Chair of the Committee. The Secretary shall be the Director of the Nutrition and Food Service Department, or designee. The Chair will have the authority to invite representative(s) from other disciplines as needed. These persons will not be members of the committee and shall have no power to vote, but may be actively involved in discussions and serve on subcommittees as needed.

B. FUNCTIONS

The Nutrition Committee shall:

1. Provide a forum for multi-disciplinary collaboration on patient care standards, revision of patient care policies and procedures, as well as reviewing clinical indicators for the purpose of improving patient care, as is applicable to nutrition.
2. Endeavor to continually enhance the provision of high quality nutrition care by identifying, establishing, incorporating and maintaining nutritional practices in accordance with scientific principles and standards as outlined by The Joint Commission, New York State Department of Health and the recognized professional society guidelines that are standards of practice for nutrition.

3. Serve a catalyst for nutrition services, including, but not be limited to, the following activities:
 - Periodic review of the Diet Manual as well as associated patient educational materials.
 - Review of the Standards of Care for nutrition.
 - Multidisciplinary review of the formulary for nutritional products, nutritional protocols, medical record forms and patient educational materials.
 - Audit and report to the PICG and Medical Board individual practices of nutrition that are not consistent with standards set forth in Paragraph B(2) above.
 - Ensure nutrition education programs for physicians, nurses, dietitians and pharmacists.
 - Coordinate of nutrition activities across departments.
 - Provide nutrition education for patients and the community at large.
 - Improve nutritional care including, but not limited to, parenteral and enteral nutrition.

C. MEETINGS

The Committee shall meet quarterly and additionally as deemed necessary by the Chair of the Committee or the Chair of the Medical Board.

PERIOPERATIVE EXECUTIVE COUNCIL (MANHASSET CAMPUS ONLY)

A. MEMBERSHIP

The Perioperative Executive Council shall be comprised of at members of the Medical Staff, representing a cross-section of disciplines involved in operative procedures. There also shall be representation from Nursing, the Postgraduate Trainee Staff, Administration, and the Operating Rooms. The Chair of the Department of Surgery serves as the Chair.

B. FUNCTIONS

The Perioperative Executive Council deals with all patient-related perioperative issues, including, but not limited to;

- Policy and Procedures
- Regulatory Standards

- Surgical Case Volumes
- Operating Room Utilization
- Post Anesthesia Care Unit Utilization
- Performance Improvement/Quality Management
- Risk Management
- Strategic Planning
- Programmatic Initiatives
- Capital Equipment Recommendations
- Customer Satisfaction

The Council regularly reports into the PICG and into the Medical Board, as necessary.

C. MEETINGS

The Council shall meet monthly.

PHARMACY AND THERAPEUTICS COMMITTEE

A. MEMBERSHIP

The Committee shall consist of members of the Medical, Administrative, Nursing and Ancillary Staff, including the Director of the Pharmacy, representatives from the Departments of Anesthesiology, Emergency Medicine, Medicine, OB/GYN, Pathology and Laboratory Medicine, Psychiatry, Radiology, Surgery and Nursing. It also shall include representatives from Administration, and others, as deemed necessary. At the Manhasset Campus, the Committee also shall include representatives from the Departments of Neurology and Pediatrics, and representatives from the Postgraduate Trainee Staff may be included as deemed necessary.

B. FUNCTIONS

The Pharmacy and Therapeutics Committee is responsible for the following:

1. Implementation and surveillance of the drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.
2. Implementation and surveillance of Northwell Pharmacy & Therapeutics policies and practices, especially as they relate to the handling, distribution, and safe administration of drugs.
3. Representation at the Northwell Pharmacy & Therapeutics Committee, providing feedback and data on pharmaceutical issues and advocating for changes in formulary and medication policy when required.

4. Review of untoward drug reactions.
5. Monitoring usage of medications with the potential for high risk, ensuring that the assessment includes clinical review, as well as trend data.
6. Serving as an advisory group to the Medical Staff and Pharmacy Department regarding pharmaceutical issues.
7. Evaluating research protocols concerned with the use of investigational or experimental drugs.
8. Reporting to the PICG at the applicable Campus and the Medical Board at the Manhasset Campus and the Leadership Coordinating Council at the Syosset Campus.

C. MEETINGS

The Pharmacy and Therapeutics Committee shall meet at least quarterly.

PROFESSIONAL LIBRARY COMMITTEE

A. MEMBERSHIP

The Professional Library Committee shall consist of members of the Medical Staff, as well as representatives from the Nursing Department, and other Departments, as needed. The Chief Academic Officer shall be an ex-officio member. At the Manhasset Campus, the Committee also may include representatives from the Postgraduate Trainee Staff.

B. FUNCTIONS

The Professional Library Committee is responsible for:

1. Ensuring the proper organization, supervision and use of the professional library, and analyzing the changing needs of the library services.
2. Through the Librarian-in-charge, the acquisition, custody and control of all professional books and periodicals, whether by purchase, subscription or gift, which are considered of value to the Medical Staff. It shall also concern itself with the deletion of any outmoded material contained in the professional library.
3. Providing advice and recommendations on matters that impact on Health Sciences Library services, collection and facilities, and matters that impact on educational informatics (the use of computers for educational purposes).
4. Promulgating rules and regulations governing the use of the library.

C. MEETINGS

The Committee shall meet at least semi-annually and as many additional times as the Chair may direct.

RADIATION SAFETY COMMITTEE

A. MEMBERSHIP

The Radiation Safety Committee shall include the Radiation Safety Officer; a representative of Administration; physician representatives, as appropriate, from Radiology, Radiation Medicine, Nuclear Medicine and Cardiology; when appropriate, an authorized user from Research, a Radiation Medicine Physicist, and a Diagnostic Radiology physicist; a representative from Nursing, and other Departments, as appropriate. The Chair of the Committee shall be the physician representative from Radiology. At the Manhasset Campus, the Committee also may include representatives from the Postgraduate Trainee Staff.

B. FUNCTIONS

The Radiation Safety Committee is responsible for:

1. The safe use of radioactive materials and ionizing radiation-producing machines.
2. Making recommendations to Administration regarding the proper use, transport, and storage of all radioactive material as set forth in the New York State Sanitary Code, the New York State Hospital Code, and the codes, directive and standards of all regulatory agencies including, but not limited to, the Bureau of Environmental Radiation Protection of the New York State Department of Health, the Bureau of Radiological Health of the City of New York, the Department of Transportation, the Department of Environmental Conservation, the New York State Department of Labor, the Occupational Safety and Health Administration, and the Food and Drug Administration.
3. Under the Hospital's Broad Scope Radioactive Materials License, reviewing and granting permission for, or disapproving, the use of radioactive material within the Hospital. All authorized users of radioactive materials must be approved by this Committee.
4. Prescribing special conditions that will be required during a proposed use of radioactive material such as requirements for bioassays, minimum level of training and experience of users or any other conditions that the Committee shall consider advisable.

5. Receiving and reviewing records and reports from the Radiation Safety Office, or individuals with delegated responsibility for radiation health and safety practices.
6. Formulating and reviewing the institutional training programs for the safe use of radioactive materials and radiation producing machines.
7. Submitting to the appropriate governmental bureaus and agencies having jurisdiction over its activities such reports as may be required by applicable governmental regulations.

C. MEETINGS

The Committee shall meet at least quarterly and as many times as the Chair may direct. A quorum shall consist of at least one-half the Committee membership, and must include the Radiation Safety Officer and the Administration representative.

TISSUE COMMITTEE

A. MEMBERSHIP

The Tissue Committee shall consist of representatives from the Departments of Surgery, Medicine, Pathology, Obstetrics and Gynecology, Orthopedics, Pediatrics, ENT, Urology and Ophthalmology. The Committee also shall include of a member of the Postgraduate Trainee Staff. Any Committee member whose case is being reviewed shall be excluded during that review.

B. FUNCTIONS

The Tissue Committee is responsible for:

1. Performing a medical audit on all patients undergoing surgery or other invasive procedures, or who shall have undergone an autopsy, in whom:
 - There exist major discrepancies between the preoperative and postoperative diagnoses in pathology reports;
 - There is a major discrepancy between preoperative diagnosis and postoperative findings; and
 - The tissue removed does not in and of itself justify the performance of the procedure.
2. For cases involving no specimen, establishing a screening mechanism based upon predetermined criteria to address concerns of appropriateness.

3. Submitting regular reports to the PICG and as necessary to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus, describing the results of all evaluations and actions taken.

C. MEETINGS

The Committee shall meet at least ten (10) times per year at the Manhasset Campus and at least quarterly at the Syosset Campus.

TRANSFUSION COMMITTEE

A. MEMBERSHIP

The Transfusion Committee shall include representatives from the Departments of Emergency Medicine, Medicine, Surgery, Pediatrics (Manhasset Campus only), Obstetrics and Gynecology, Orthopedics and Anesthesiology. The Committee Chair shall be the Director of the Blood Bank. At the Manhasset Campus, the Committee also may include a member of the Postgraduate Trainee Staff.

B. FUNCTIONS

The Transfusion Committee shall review blood transfusions for proper utilization. A report must be completed for each actual or suspected transfusion reaction. Particular attention shall be given to the use of whole blood versus component blood elements. A review of the amount of blood requested, the amount used and the amount of wastage shall be included in the evaluation.

C. MEETINGS

The Committee shall meet as frequently as necessary, but at least quarterly. The Committee shall report regularly to the PICG and as necessary to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus.

3. MEETINGS OF THE OPERATIONAL COMMITTEES. Except as otherwise specified above, each Operational Committee shall meet quarterly and additionally as deemed necessary by the Chair of the Committee, the Chair of the Medical Board, or the Executive Director. Minutes of each meeting shall be kept and shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed; recommendations made; and actions taken. Copies of such minutes and of all Committee reports and recommendations shall be forwarded by each Committee to the administrator responsible for the subject matter within the Committee's jurisdiction, and to the Medical Board at the Manhasset Campus and to the Leadership Coordinating Council at the Syosset Campus, or to the committee thereof with such responsibility.

4. SPECIAL MEETINGS. The Executive Director, the Chair of the Medical Board/Leadership Coordinating Council, and the Chairmen of the Operational Committees may call special meetings of such Committees upon such notice as may be practicable under the circumstances.
5. OTHER OPERATIONAL COMMITTEES. Unless otherwise expressly provided in the Medical Staff Bylaws or elsewhere in these Rules and Regulations, additional committees may be appointed by the Executive Director in such number and of such composition as he or she may deem necessary or desirable to properly carry out the operations of the Hospital. Such committees shall confine their activities to the purposes for which they were appointed, shall report to the Hospital administrator with responsible for the subject matter within the Committee's jurisdiction, and to the Medical Board/Leadership Coordinating Council, or the committee thereof with such responsibility, and shall have only such power of action as is specifically granted by the Executive Director.

T. CLINICAL DEPARTMENTS

The Clinical Departments at the Manhasset and Syosset Campuses are:

- a) At the Manhasset Campus:

- Anesthesiology
- Cardiology
- Cardiovascular and Thoracic Surgery
- Dental Medicine
- Dermatology
- Emergency Medicine
- Family Medicine
- Medicine
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Occupational Medicine, Epidemiology and Prevention (OMEP)
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology and Laboratory Medicine
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry
- Radiation Medicine
- Radiology
- Surgery
- Urology

b) At the Syosset Campus:

Anesthesiology
Dermatology
Emergency Medicine
Family Medicine
Laboratory/Pathology
Medicine
Gynecology
Orthopedic Surgery
Pediatrics
Psychiatry
Radiology
Surgery

U. ADDITIONAL REFERENCE MATERIALS

In addition to the Medical Staff Bylaws and the Rules and Regulations promulgated herein, the members of the Medical Staff, the Postgraduate Trainee Staff and the member of the Allied Health Professions Adjunct Staff are bound to comply with all other policies and procedures that are currently in effect or that may hereinafter be developed by the Hospital, including those developed by their Department Chair. The following is a list of documents, which are readily available on the nursing units and should be sought when questions related to their subject matter arise.

- a) Administration Policy and Procedure Manual
- b) Patient Care Policy and Procedure Manual
- c) Infection Control Policy and Procedure Manual
- d) Safety Manual
- e) Fire and Disaster Plans
- f) Clinical and Ancillary Department Manuals, i.e., Pharmacy, Dietary
- g) Policy on Impaired Physicians
- h) Resident/Fellow Manual